
Public Hearing

before

ASSEMBLY FEDERAL RELATIONS COMMITTEE AND ASSEMBLY SENIOR ISSUES COMMITTEE

“Testimony on the Federal ‘Medicare Prescription Drug, Improvement and Modernization Act of 2003,’ plus testimony on coverage for prescription drugs under Part D of the Federal law and how New Jersey can address the gap in prescription drug coverage under the Federal law.”

LOCATION: Committee Room 11
State House Annex
Trenton, New Jersey

DATE: November 23, 2004
10:00 a.m.

MEMBERS OF JOINT COMMITTEES PRESENT:

Assemblyman Reed Gusciora, Co-Chair
Assemblywoman Nellie Pou, Co-Chair
Assemblywoman Linda R. Greenstein, Co-Vice Chair
Assemblyman Robert J. Smith II, Co-Vice Chair
Assemblywoman Joan M. Voss
Assemblyman Guy R. Gregg
Assemblyman Joseph Pennacchio
Assemblyman Anthony Chiappone
Assemblyman Bill Baroni
Assemblyman Sean T. Kean



ALSO PRESENT:

Catherine Z. Brennan
Irene M. McCarthy
*Office of Legislative Services
Committee Aides*

Jessica Perl
Stephanie Mash
*Assembly Majority
Committee Aides*

Thea M. Sheridan
Jennifer J. Rasch
*Assembly Republican
Committee Aides*

***Hearing Recorded and Transcribed by
The Office of Legislative Services, Public Information Office,
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey***

*Office of Legislative Services
Committee Aides*

*Assembly Majority
Committee Aides*

*Assembly Republican
Committee Aides*

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ASSEMBLYWOMAN NELLIE POU (Co-Chair): Good morning, ladies and gentlemen. We're about to begin our meeting. Before we begin, I'd like to ask that roll call be taken.

MS. McCARTHY (ASI Committee Aide): Assemblyman Kean?

ASSEMBLYMAN KEAN: Yes.

MS. McCARTHY: Assemblyman Baroni?

ASSEMBLYMAN BARONI: Yes.

MS. McCARTHY: Assemblyman Chiappone?

ASSEMBLYMAN CHIAPPONE: Here.

MS. McCARTHY: Assemblyman Smith? (no response)

He's here.

Assemblywoman Pou?

ASSEMBLYWOMAN POU: Here.

MS. McCARTHY: Thank you.

MS. BRENNAN (AFR Committee Aide): Assemblyman Pennacchio?

ASSEMBLYMAN PENNACCHIO: Here.

MS. BRENNAN: Assemblyman Gregg?

ASSEMBLYMAN GREGG: Here.

MS. BRENNAN: Assemblywoman Voss?

ASSEMBLYWOMAN VOSS: Here.

MS. BRENNAN: Assemblywoman Greenstein?

ASSEMBLYWOMAN GREENSTEIN: Here.

MS. BRENNAN: Assemblyman Gusciora?

ASSEMBLYMAN REED GUSCIORA (Co-Chair): Here.

ASSEMBLYWOMAN POU: Thank you very much.

Good morning, again, and welcome to the Joint hearing to address Federal law that causes a gap in prescription drug coverage. We look forward to hearing testimony from several groups today, as we explore New Jersey's options in preparing for major changes in Medicare prescription drug coverage.

This meeting is a follow-up to a prior Assembly Federal Relations Committee hearing that was held in February.

As many of you know, a new Medicare prescription drug benefit will replace Medicare drug coverage for low-income Medicare beneficiaries, as soon as 2006. Part D of the Medicare Prescription Drug Improvement and Modernization Act of 2003 will require major policy changes in the way that the State provides Medicaid. These changes will affect New Jersey's PAAD and Senior Gold programs for our neediest senior citizens. With such sweeping and significant change, the Legislature has the daunting task of implementing this new law, while still giving dual beneficiaries the best possible assistance.

The State has several concerns. Among them are determining eligibility requirements, and whether the State should supplement Part D coverage, and coordinating benefits. We are particularly concerned with the coverage gap this law will create, and will determine ways to help close it. I think it's important that our Committee members here today -- our part here today is to really try to listen carefully to the testimonies that are going to be provided to us. We're very interested in hearing what you have to say. We're interested in receiving the information so that we can better prepare ourselves, and be better equipped and better prepared to make proper changes and take the appropriate action on behalf of our constituents and all the residents in the State of New Jersey.

I'd like to, at this time, turn to my colleague, Assemblyman Reed Gusciora, who is the Chairman of the Federal Relations Committee, for any opening remarks.

ASSEMBLYMAN GUSCIORA: Thank you, Madam Chair.

I'm honored to be part of this historic effort. On behalf of the members of the Federal Relations Committee, this is a continuing hearing into how the new Federal prescription program will affect our prescription program. We have the oldest prescription program in the nation, and probably the best. I want to make sure that we get optimum dollars from the Federal Government. I think that will be done on a bipartisan effort, so that at the end of the day our citizens will greatly benefit from this Federal program and be able to dovetail into our State program.

I also wanted to thank our members for coming in on their day off. We hope that this is going to be productive, and look forward to hearing the testimony so that we can better serve the people of the State of New Jersey.

Thank you.

ASSEMBLYWOMAN POU: Thank you very much.

We also would like to thank all the members that are present here, our guests, for taking the time to -- being with us on this very important meeting.

At this time, what I'd like to do is ask our first person that-- I have a list of names here that want -- of people who -- and organizations that wish to testify. If there are no opening comments or remarks from any of our members, I'd like to just proceed with our first speaker.

I'm going to call upon a representative from the Department of Health and Senior Services, Kathy Mason, who is the Assistant Commissioner from the Department of Health and Senior Services. If you could please come

forward. Good morning, and thank you so very much for being here with us, Kathy.

ASST. COMMISSIONER KATHLEEN MASON: Thank you.

ASSEMBLYWOMAN POU: Thank you, Assistant Commissioner. Please-- Thank you.

ASSISTANT COMMISSIONER MASON: Thank you.

Madam Chair, Mr. Chairman, members of the Committee, my name is Kathleen Mason. I am the Assistant Commissioner of the Division of Senior Benefits and Utilization Management in the Department of Health and Senior Services. My division administers New Jersey's State pharmacy assistance program, the Pharmaceutical Assistance to the Aged and Disabled Program; and the Senior Gold Prescription Discount Program. Thank you for the opportunity to speak about the new Medicare drug program and its relation to our State programs.

Please know that we have not yet made final decisions about how to coordinate benefits between the new Medicare drug program, and the PAAD and the Senior Gold programs. In fact, partly because the final regulations concerning the Medicare drug program have not been released yet by the Centers for Medicare and Medicaid Services, so many decisions remain unknown at this point, even by the Federal Government.

Currently, we are operating under the interim Medicare discount card -- an 18-month program that provides immediate relief to certain Medicare beneficiaries, without other drug coverage or with low incomes, until the new Medicare drug program is put in place in 2006. Enrollment in the Medicare discount cards and the Transitional Assistance Program for low-income beneficiaries began in May 2004, and the discounts started in June 2004.

The Medicare discount card has two parts: First, the Medicare approved discount cards offer eligible seniors and disabled individuals, who apply and pay an enrollment fee, an estimated 10 percent to 25 percent savings off of retail prices -- for drugs covered by the selected discount card -- at specific pharmacies that participate in the selected discount card programs network. Second, discount card enrollees who have incomes below \$12,569, if single, or \$16,862, if married, which is 135 percent of the Federal poverty level, are also eligible for Transitional Assistance, which is a \$600 credit in 2004 and another \$600 credit in 2005 on the discount card they have selected. Transitional Assistance beneficiaries also pay a 5 percent to 10 percent copayment on each drug purchased.

Discount card program sponsors may charge up to a \$30 enrollment fee, but the Federal Government pays the enrollment fee for low-income beneficiaries that are eligible for Transitional Assistance.

There are many different Medicare discount cards offered in New Jersey for seniors to chose from. Each offers different discounts on different drugs, and may have different networks of pharmacies that participate. Choosing which plan to enroll in is a confusing and time-consuming process for many seniors and those people who try to assist them.

The State determined that for many of its PAAD and Senior Gold beneficiaries, their State benefits were far superior to those offered by Medicare discount cards. We recommended that these beneficiaries not waste their time or money to enroll in a Medicare discount card. However, for the 81,000 PAAD beneficiaries who have income below 135 percent of poverty and qualify for Transitional Assistance, the State recommended these beneficiaries take advantage of the financial assistance offered by the Federal Government. The

only way for our beneficiaries to receive the Transitional Assistance was to enroll in a Medicare discount card.

In April of 2004, after an extensive lobbying effort on the part of the state pharmacy assistance programs, AARP, and PHRMA, the Federal Government decided to allow states to automatically enroll low-income beneficiaries of state pharmacy assistance programs into a preferred Medicare discount card, provided that the state give such beneficiaries the chance to opt out of the automatic enrollment process. New Jersey took advantage of this decision for its low-income PAAD beneficiaries, because the process eliminated the confusion and the paperwork involved in enrolling in a Medicare discount card.

New Jersey developed an RFP to identify a preferred provider for the Medicare discount card and the PAAD program. Through the request for proposal, the RFP, the State contracted with Medco Health Solutions, Incorporated, to act as the preferred provider. Out of the 81,000 PAAD beneficiaries eligible for the Transitional Assistance, only 350 chose to opt out of the State's automatic enrollment process into the PAAD/Medco discount card program, reinforcing the notion that they were comfortable with the State making that decision for them.

The PAAD program estimates that it will cost avoid, or save, \$90 million, over the 18-month period that the Medicare discount card is in existence, by automatically enrolling its 81,000 eligible PAAD beneficiaries for the Transitional Assistance into the Medco discount card. I'm happy to report that as of November 5, 2004, almost 697,000 claims have been processed by Medco for PAAD beneficiaries, saving the PAAD program over \$33 million already by using the Medicare discount card program.

PAAD beneficiaries that use the Transitional Assistance do not incur any additional costs. They still only pay their regular \$5 copayment and less for prescriptions under \$50. In fact, some of the beneficiaries are experiencing lower copayments, because the 5 percent or 10 percent copayment under Transitional Assistance can be lower than the \$5 copayment, for drugs that cost less than \$50. Their enrollment fee to use the Medicare discount card is paid by the Federal Government, and the PAAD program pays the difference between the 5 percent or 10 percent coinsurance on each claim and the regular \$5 copayment.

The automatic enrollment process into a preferred provider of the Medicare discount card has been a relatively seamless transition with no disruption or loss of service for PAAD beneficiaries. The only noticeable change for low-income PAAD beneficiaries is a new identification card showing they are eligible for prescription benefits under both PAAD and the Medicare discount card offered through Medco.

The State would also like the ability to automatically enroll its PAAD and Senior Gold benefits, with the beneficiary's ability to opt out, into a preferred provider for the comprehensive drug program that Medicare will offer in 2006. Too many different prescription drug program options, including different formularies, will mean that many of our beneficiaries will not choose any plan. Therefore, the State would like to have a preferred provider for the Medicare drug benefit, again in 2006.

As I indicated earlier, decisions about how to wrap around State benefits with the 2006 Medicare drug program are undecided. We submitted lengthy comment to CMS on the proposed regulations regarding the Medicare drug program. We continue to raise such questions as: Who will determine the eligibility of a PAAD beneficiary for the subsidy assistance that will be available

under the Medicare drug program for low-income beneficiaries? The State has proposed that they would like the State pharmacy assistance program to be deemed an entity to automatically enroll, and determine eligible for subsidies, those that would qualify for low-income subsidies.

Will State pharmacy assistance programs be permitted to automatically enroll their beneficiaries in a preferred provider, as they so successfully did in the discount card? That question still remains unanswered. And in fact, we've received information that Senator Grassley's Committee has received a legal opinion that would discourage the ability for states to do that at this point.

The Medicare drug program includes an asset test. New Jersey's State pharmacy assistance program does not. How can we collect the asset test information for our beneficiaries to simplify this process for them?

If the State pays premiums for its beneficiaries, how will that process be set up? Will we pay CMS or each PDP provider separately?

And will State pharmacy assistance programs be permitted to appeal the denial of coverage of drugs not on the plan's formulary on behalf of their beneficiaries? These are all included in our comments on the regulations.

While we have questions about how to coordinate State program benefits with the Medicare program, we're currently focusing our efforts on being able to automatically enroll our beneficiaries into a preferred prescription drug plan approved by CMS. We would appreciate any assistance these Committees can provide in lobbying CMS to allow the State to do this. New Jersey's seniors and disabled residents should be able to utilize the Federal benefits for which they are entitled without a reduction in the comprehensive benefits they now enjoy.

I would be happy to answer any questions the Committee has at this point.

ASSEMBLYWOMAN POU: Thank you so very much, Assistant Commissioner. We really appreciate your testimony.

I think one of the things that -- and I'd like to just make this comment so that any and all of the other folks that are going to testify make it as part of their testimony, available to us. There are two particular things that we would like to see come out of this hearing today. And that is, and perhaps maybe if you want to talk more about this, let me know please. One is, what the group is finding on the impact of the coverage gap on their particular interest group. Again, let me just repeat that. The group's finding on the impact of the coverage gap on their interest group, and any recommendation for legislative action that may address the coverage gap. I think this is important to us, as we're preparing and trying to obtain information, so that our Joint Committees can better prepare itself for that type of information.

Is there anything further that you'd like to add towards any one of those two particular questions, Assistant Commissioner, before I open it up for questions?

ASSISTANT COMMISSIONER MASON: Just that the experience that we had with the discount card worked beautifully, and our-- We have had very, very minimal questions or concerns raised by the PAAD beneficiary on using the discount card. And I strongly believe the success of that program was based on our ability to use one preferred provider and automatically enroll that.

But as I said in the testimony, last week we received information back regarding the legal opinion that Senator Grassley obtained recently, indicating that there's a very strong possibility that CMS would not approve an

automatic enrollment process and a preferred provider for our beneficiary population. The thought of having 220,000 people on PAAD have to compare the many prescription drug plans that would be available, and make a decision about that, is overwhelming to me, let alone to all those beneficiaries in our population. And I really think the only way that we could assure the maximum savings with the minimal disruption to our beneficiaries would be to push it through any lobbying efforts possible -- for the Center for Medicare and Medicaid Services to recognize that the discount card was only a success to the point that automatic enrollment worked. In fact, statistics show that over 80 percent of the people in the country currently enrolled in the discount card were automatically enrolled by either Medicare Advantage program, a Medicare HMO, or a state pharmacy assistance program.

In fact, New Jersey was one of the first, if not the first state, to automatically enroll their population. And we received benefits for our population on June 1. The first day anybody could benefit from the discount card cost savings, we were experiencing those savings for our program. Without automatic enrollment, our population would have been overwhelmed. They also have absolutely no incentive to go through the process of getting determined eligible for subsidy assistance, or picking a plan. Most PAAD beneficiaries are quite happy with the coverage that they have now, and have no incentive to go through that paperwork if we don't do that for them, if we don't help them with those decisions, and we don't eliminate the paperwork as we did -- the discount card.

In fact, the paperwork is even more complicated in 2006 than it was in the discount card, because low-income beneficiaries have to first apply to either the Social Security Administration or the Medicaid office to be determined eligible for a low-income subsidy; and then, as a second step, pick

a plan and enroll directly with the plan. So there's a two-step process with -- our beneficiaries would need to go to two different agencies to complete the process -- in order to be determined eligible for the low-income help subsidies for premiums and deductibles, and also to enroll in the process.

I'm sure all of you can imagine what a job it would be to get 220,000 people to go through a process like that, when they're perfectly content with the benefit they have now and have no incentive to do so.

ASSEMBLYWOMAN POU: Isn't there an administrative cost that would certainly also create some problems, or increase in that, as a result of the change that you were referring to?

ASSISTANT COMMISSIONER MASON: Yes. And I think that the Federal Government is even acknowledging how awesome an assignment this is, because New Jersey was given \$11.3 million in this Federal fiscal year, and another \$11.3 million for the following Federal fiscal year, to assist beneficiaries in this process. The fact that we were given that much money, I think, reinforces that even the Federal Government sees this as a major undertaking -- for state pharmacy assistance programs to educate their beneficiaries and help them through the enrollment process -- a lot of which could be simplified with an automatic enrollment process and working with one preferred provider.

Also, the thought of, on an ongoing basis, having to coordinate PAAD benefits with five or six different prescription drug plans, on an ongoing basis for years to come, would be extremely difficult -- which would further be simplified if we had one plan to work with, as we did with the discount card.

ASSEMBLYWOMAN POU: Thank you very much.

Mr. Chairman.

ASSEMBLYMAN GUSCIORA: Thank you, Commissioner, for coming. We appreciate any help as we go through this process.

As one preliminary, has the Department had to add any personnel to administer this program? Have you experienced any cost, administratively, to implement this program?

ASSISTANT COMMISSIONER MASON: Yes.

In fact, Cynthia McGettigan, who is in the -- seated behind me -- was hired specifically to help with the implementation of the drug program. We also were in the process of hiring additional hot-line staff, using some of that \$11.3 million funding that we had. And we're also looking to increase staff out in the field to actually help people with making these decisions and trying to alleviate-- We frequently hear from PAAD beneficiaries that they're concerned, that they don't want to lose the coverage that they have. And a lot of our challenge is to reassure people that we are doing everything we can to maximize the Federal benefits available to us with minimal change to the program. Luckily, the discount card, I think, was reassuring to many beneficiaries, because they have been very comfortable with the process that we set up now. My concern is whether we will be able to do it as seamlessly in the future.

ASSEMBLYMAN GUSCIORA: And then I guess my question is, will there be beneficiaries under the State program that will lose benefits? Can we guarantee the New Jersey public that because of the Federal program they're going to have greater benefits, or how does that work?

ASSISTANT COMMISSIONER MASON: As long as there's no change in State legislation, the program, as exists now, allows people to be on PAAD with other prescription coverage, but that program becomes the primary payer and PAAD would become secondary. That certainly is the process that we hope to set up for 2006. It would require a change in legislation to reduce the benefits provided under the PAAD program.

For example, if we were not to cover drugs that were not on the prescription drug plan's formulary, that would require a change in the legislation, because the current PAAD law says that the beneficiaries are entitled to all prescription benefits, as long as that manufacturer pays a rebate to the State. So, under current legislation, the program continues to operate as it does, but we would use the Medicare benefits as primary.

ASSEMBLYMAN GUSCIORA: Now, for those who are low-income beneficiaries, will they have increased costs or will their benefits remain the same?

ASSISTANT COMMISSIONER MASON: No. Actually -- if we can get them to enroll in the subsidy program -- they could actually have a lower copayment under the Medicare program. The benefit for the population below 135 percent of poverty, under the Medicare Part D plan, is really quite extensive. And even if the beneficiaries could experience a lower copayment-- But the problem is, we need to get them to enroll in the low-income subsidy program, which I said, currently, would require them to apply to either the Social Security office or the Medicaid office.

In our comments to the regulations, we proposed and have asked CMS, both through the State comments on the regulations and through comments submitted by the State Pharmacy (*sic*) Assistance Transition Commission -- a Federal Commission that we are represented on -- we've asked that the PAAD program be allowed to be an entity that would determine eligibility. That would mean we'd have to collect asset information from our beneficiaries in order to see if they qualify for the low-income subsidy. But certainly, we believe it would be easier for our population if they submitted that information to us as part of the PAAD application process, as opposed to having to go through Social Security or the Medicaid District Office. Again, I

don't think our population would do that, unless we coordinated that through the PAAD office where they're comfortable in submitting that information. Again, that's a decision pending with CMS, and we don't know which way they'll rule on that. But it would seem to be both in their interest and ours that they allow the PAAD office to determine eligibility.

ASSEMBLYMAN GUSCIORA: As a ballpark, how much does it cost for us to run the prescription program, both PAAD and Senior Gold?

ASSISTANT COMMISSIONER MASON: Administrative costs?

ASSEMBLYMAN GUSCIORA: Just the cost of the program.

ASSISTANT COMMISSIONER MASON: The cost of the program is about \$600 million. It's over \$560 million in benefit costs for the PAAD program, and another 20 million for Senior Gold.

ASSEMBLYMAN GUSCIORA: Now, do you envision any savings from the Federal Government? How much will we get back from the Federal Government?

ASSISTANT COMMISSIONER MASON: How much we save depends on a lot of decisions that have yet to be made. The primary one is how many people sign up for the low-income subsidy program, how many people enroll to begin with. Even whether they're eligible -- they're considered low income and get subsidy assistance, or not, on the program. Whether the -- decisions that have to be made is whether the program will completely wrap around benefits, whether it will cover a drug that's not on the plan's formulary under the PAAD program. Those are all outstanding decisions that would affect how much we save. But the biggest savings would be dependent on how many people actually sign up and join a plan, and automatic enrollment would certainly increase the projection of savings. But we don't know we have that yet.

ASSEMBLYMAN GUSCIORA: Do you envision any scenario that we will actually get 600 million from the Federal Government, or will we get half of it, or-- What do you think is the potential of us -- what kind of windfall or reimbursement do we expect to get from the Federal Government?

ASSISTANT COMMISSIONER MASON: Again, that would depend on decisions about how much the PAAD program was going to wrap around. If we're going to pay for nonformulary drugs, the savings would be less than if we require the beneficiaries to go to a participating pharmacy in the prescription drug plans network and utilize formulary drugs, or whether the State will pick up a drug that's not covered on the plan's formulary. And also, on how many people actually enroll in the subsidy programs. About 80,000 of our population will be eligible for the subsidies, even with the asset test that will be required in order to be determined eligible. We project about 80,000 of our people would qualify for low-income subsidies. The rest of the population would not qualify for subsidies, and then would experience the deductible and the donut hole that you've heard talked about -- the gap in coverage. But PAAD coverage would still be there to fill in those gaps.

ASSEMBLYMAN GUSCIORA: Great. My final question is about the clawback. My understanding is that because we have a program in place, we'll actually have to pay money to the Federal Government?

ASSISTANT COMMISSIONER MASON: Yes. That's for the Medicaid program. Again, the Medicaid program is administered from the Department of Human Services. But I do have a basic understanding of the clawback provision, in that, initially, in 2006, the states are required to pay 90 percent of what they would have paid in their State contribution for the Medicaid program to the Federal Government, in the form of what is called the *clawback*. So though Medicaid beneficiaries have to use Medicare coverage, the

Medicaid drug program for dual-eligibles goes away in 2006. States still have to contribute to the costs of that clawback. However, as I said, that is under the Department of Human Services, so I would defer to them for more detail.

ASSEMBLYMAN GUSCIORA: Thank you.

Thank you, Madam Chair.

ASSEMBLYWOMAN POU: Thank you very much, Assistant Commissioner.

Are there any questions from any members?

Assemblywoman Greenstein.

ASSEMBLYWOMAN GREENSTEIN: Thank you.

Good morning.

ASSISTANT COMMISSIONER MASON: Good morning.

ASSEMBLYWOMAN GREENSTEIN: Thank you for coming.

I just had two areas that I wanted to ask you about. One is, how do you envision that this new program would affect more of the middle-income buyer of prescription drugs? Because as you know, the costs have gone so high that they're affecting everybody -- certainly the low-income people the most. But middle- and even upper-income people are very affected by the high cost of some of these prescription drugs. Will this program help these people, or will it only be people who qualify for the Senior Gold and the PAAD?

ASSISTANT COMMISSIONER MASON: No. The population over the Senior Gold limit -- those who currently don't qualify for assistance through the State program -- can still voluntarily enroll in the Medicare Part D program. They're the group that would -- if their income is higher than Senior Gold and (indiscernible) -- would have a \$250 deductible, would have the gap in coverage -- the donut hole, as referred to -- but then also would qualify for the catastrophic coverage. So for people with high drug costs, they would have to

pay a premium of about \$35 a month. But depending on the drug costs, certainly many beneficiaries could see a substantial savings. In fact, our-- Utilizing the average cost in the PAAD program -- would still appear to be a savings for the majority of our population who don't qualify for the low-income subsidies, to still enroll in the program.

ASSEMBLYWOMAN GREENSTEIN: Can you just give an example when you say a substantial savings? What would be an example on a particular drug that you might be familiar with, the type of savings that might be realized here?

ASSISTANT COMMISSIONER MASON: If a person had drug costs of \$100 a month, which is certainly not unusual, they pay a \$35-a-month premium. The first \$250 would count towards their deductible, but then they would only pay 25 percent of the drug costs until they reach the donut hole, the gap in coverage. So for that period then, when they reach that gap, they would pay for their costs in full. However, even during that period, the regulations require the prescription drug plans to pass on to beneficiaries what's called *negotiated prices*. So they would still see a reduction to their total out-of-pocket cost, even during the donut hole, because the prescription drug plan is supposed to pass on savings that they receive, as an example, through negotiating with a pharmacy for a lower reimbursement rate for the pharmacy; and rebates that they would receive from the manufacturers are supposed to be passed on to people even during that donut hole. So there -- it still would be cheaper than they would pay out of pocket without a Medicare drug program. And then once they reach the catastrophic cap of \$3,600, then the catastrophic coverage kicks in again, and they would again receive substantial savings after, from that one on.

ASSEMBLYWOMAN GREENSTEIN: Right now, these people that we're talking about, above the Senior Gold level, don't get any benefit. Is that right?

ASSISTANT COMMISSIONER MASON: Right. Unless they have other prescription coverage from their employer. But certainly, every day we hear from beneficiaries who, unfortunately, are just a few dollars over the Senior Gold limit and are just looking for some help. And the Medicare drug program, especially for higher -- people who utilize higher amounts of drugs, is going to be a huge benefit for them.

ASSEMBLYWOMAN GREENSTEIN: Now, I also just wanted to ask you about the PBMs, the Pharmacy Benefit Managers.

ASSISTANT COMMISSIONER MASON: Yes.

ASSEMBLYWOMAN GREENSTEIN: Do you envision, once this program gets going, a larger role for them, a smaller role? Because I've always been concerned. I even have some legislation in about that issue. I wondered if they might be somewhat part of the costs going up in our system. And I wondered if they would have a larger role here?

ASSISTANT COMMISSIONER MASON: The program will be administered by what is called *prescription drug plans*, which are likely to be PBMs rolled into a new risk-bearing entity that will administer these programs. And in fact, anyone who enrolls in the Medicare Part D program either has to sign up with a Medicare HMO, Medicare Advantage Program that has prescription coverage, or with a prescription drug plan, called a PDP, and those entities are likely to be very similar to PBMs. They will be negotiating rebates with drug manufacturers. They'll be identifying a network of pharmacies and actually will be the entity that administers the plans.

ASSEMBLYWOMAN GREENSTEIN: Okay. Thank you.

ASSEMBLYWOMAN POU: Thank you.

Assemblyman Pennacchio.

ASSEMBLYMAN PENNACCHIO: Thank you, Madam Chairwoman.

Thank you, Commissioner.

How are you today?

ASSISTANT COMMISSIONER MASON: Very well, thank you.

ASSEMBLYMAN PENNACCHIO: I enjoyed the participation in learning, and it seems that we're on the right road. There's some bumps, but they're -- through your efforts, we're smoothing out those bumps.

Speaking of bumps, you had discussed briefly about some of the administrative and bureaucratic concerns that we had, and you had used the word *seamless*. So I assume that those concerns are being met and that nobody is suffering because of whatever bureaucratic or administrative concerns there were.

ASSISTANT COMMISSIONER MASON: No. Actually, I'm happy to report that I cannot think of one complaint that we received through the Governor's Office. I've worked in the PAAD program for 25 years, and I was worried about what a change of this magnitude would do to our population. It worked beautifully. Most people who are utilizing the combined benefit -- using the discount card and the PAAD program -- I don't think even realize what is going on. Because it is really handled at the pharmacy. The pharmacy submits the claim to the Medicare discount card, then submits a second claim over to the PAAD program for the balance. The beneficiaries are just showing the new card that we sent to them, and they didn't have to fill out any paperwork. They didn't have to do anything. We kind of took care of everything for them.

ASSEMBLYMAN PENNACCHIO: Through the Chair, that's quite, I'm sure, through all your efforts and the Department's efforts.

It was mentioned that there were additional administrative needs that were required, and I assume some moneys. Eleven-point-three million dollars was given to us for this year, and \$11.3 million you had mentioned for next year. And you had said some of those moneys were used. Could you tell us how much was used and what happened to the rest?

ASSISTANT COMMISSIONER MASON: Well, actually, we just received the grant in October. The problem with spending the money at this point is, we don't have the final regulations back from CMS to know whether we're going to be allowed to have automatic enrollment, whether we're going to have one preferred provider. So the grant money was dedicated to be used for educating beneficiaries and setting up the coordination of benefits between the PAAD program and the Medicare program. Until we get these decisions back from CMS, about whether we will be using one preferred provider or whether we have to coordinate benefits with all of them, it's very hard to begin an education campaign with our beneficiaries when we can't tell them what the plan will be yet.

We're expecting the final decisions out from CMS in late January or February. At that point, we will be more in a position to roll out the 2006 benefit. For now, we're gearing up with bringing on additional hot-line staff to our office. I'm training people in the PAAD program and letting them know how we did the discount card, which hopefully will be a model for 2006. And we're working with our State Health Insurance Program, the SHIP volunteers that are out in the community that help people with Medicare billing problems now, and we're hoping to give some money to those groups out in the community so that they can bring on more staff and do some one-on-one

presentations at senior groups. But we're also looking at upgrading some computer systems at PAAD -- can certainly -- the claims processing issues and file sharing that will need to go on in 2006 will be huge. And so some of the moneys will be used for that. But at this point, since we just received the grant in October where -- and since we don't have decisions yet on how the plan will be rolled out, we haven't drawn down very much of that money yet.

ASSEMBLYMAN PENNACCHIO: Again, through the Chair, you had said *some*. Can we have that guarantee that Assemblyman Gusciora is talking about, that all those \$20-something million will be used to make this program seamless and to advertise the program and--

ASSISTANT COMMISSIONER MASON: And certainly the grant specifies that it can only be used for those purposes.

ASSEMBLYMAN PENNACCHIO: Good. You had also, through the Chair, mentioned, a few times, assets. Is there a difference between assets and means testing? Do we ask people if they own a house, as opposed to how much money they make?

ASSISTANT COMMISSIONER MASON: Right. That will be a big change for our population. Now beneficiaries from PAAD only have to submit their income to PAAD. The Medicare drug program includes a liquid asset. They won't count the person's principle place of residence or vehicles, but money in the bank, stocks and bonds will now count toward determining who is eligible for the low-income subsidies. So if we're going to get the PAAD beneficiaries to maximize the Federal savings, by utilizing those subsidies for low-income people, we will need to get them to report asset information.

ASSEMBLYMAN PENNACCHIO: Okay. And through the Chair, you had used the example of \$100 a month being spent on drugs. But that

\$100 does not meet the -- doesn't go anywhere near the donut. The donut is at least twice that amount. Am I correct?

ASSISTANT COMMISSIONER MASON: Right. And there is no spend-down provision for the asset determination. They have to meet the asset limit, no matter what the drug costs are, in order to qualify for low-income assistance.

ASSEMBLYMAN PENNACCHIO: Okay. And again, through the Chair, your numbers on PAAD and Senior Gold are roughly \$600 million a year. My concern, as was Assemblyman Gusciora's concern, is that this moneys gets funneled back into the patient population. We are expecting a \$2.8 billion amount of moneys coming in, roughly a \$280 million-a-year revenue stream from the Federal Government. Can we have that guarantee that that \$280 million will be used in addition to, and not instead of, the cost of running these programs, supplementing them, enhancing them, making them better, as opposed to just taking the moneys and using it for general revenues?

ASSISTANT COMMISSIONER MASON: Expanding the PAAD or Senior Gold benefits, of course, would require a change in legislation. So that would be out.

ASSEMBLYMAN PENNACCHIO: I mean, fixing the donut and maybe taking care of some additional people that are on the cusp, as far as middle income and things like that, through the Chair.

ASSISTANT COMMISSIONER MASON: Again, that would require legislative change.

ASSEMBLYMAN PENNACCHIO: I understand that. But that would require legislation. Is there anything right now that you know that's being worked out, through your Commission, where those moneys would not be used for providing, enhancing, enriching these senior programs -- for

prescription programs for seniors? For instance, making it simple -- right now, we spend roughly \$600 million a year for Senior Gold and senior PAAD, towards benefits for prescriptions for seniors. Can it be safe to say, can we have that guarantee, that when all is said and done and the revenue stream starts coming in-- The number that we have is 2.8 billion. So figure \$280 million a year. Can we have that guarantee that it will be 280 million a year on top of the \$600 million a year that we're already spending?

ASSISTANT COMMISSIONER MASON: That would be part of, I'm sure, discussions during Appropriations hearings and the final appropriation voted on by the Legislature. At this point, the \$90 million projected to be saved on the discount card is actually reducing the cost to the PAAD program. The budget was reduced by the \$90 million.

ASSEMBLYMAN PENNACCHIO: And finally, through the Chair, again we have this revenue stream of \$2.8 billion, and it reminds me of the revenue stream that we were projecting for a tobacco settlement, which at one time we were thinking that it would be used for health-care services, catastrophic services, and things like that. Do you know, are there restrictions on this \$2.8 billion where New Jersey would not be able to securitize it and borrow off of it?

ASSISTANT COMMISSIONER MASON: I'm sorry. I'm not familiar with that.

ASSEMBLYMAN PENNACCHIO: Okay.

Thank you, Madam Chairwoman.

ASSEMBLYWOMAN POU: Thank you, Assemblyman.

Assemblyman Chiappone.

ASSEMBLYMAN CHIAPPONE: Thank you.

Thank you, Commissioner.

A question in regards to the \$33 million that was saved by going to a preferred medical discount card provider. Was any of that savings due to beneficiaries receiving less of a discount on their prescription drugs?

ASSISTANT COMMISSIONER MASON: That savings is a result of beneficiaries using their \$600 credit before they used their PAAD benefits. So when they go into the pharmacy, the pharmacist bills the Medco Medicare Discount Card first, and any costs that are not covered under Medicare are then billed to the PAAD program. The \$33 million reflects that savings from cost avoiding, from billing Medicare first.

ASSEMBLYMAN CHIAPPONE: So you don't think there was any impact on the discount to prescription drugs, in themselves?

ASSISTANT COMMISSIONER MASON: No PAAD beneficiary paid more than a \$5 copayment. In fact, some paid less than \$5, because the 10 percent coinsurance for a \$50 drug claim could be less than the \$5 copayment. So no one was disadvantaged. In fact, some had a reduction in their copay.

ASSEMBLYMAN CHIAPPONE: In regards to the 350 that opted out, I assume they opted out because there was an advantage to opting out, to going to another provider. Would you know what that advantage would be?

ASSISTANT COMMISSIONER MASON: Actually, the 350 that opted out just did so out of fear.

ASSEMBLYMAN CHIAPPONE: Really.

ASSISTANT COMMISSIONER MASON: They could not believe that signing up for the Medicare drug program would not cost them something. They were so happy with their PAAD benefits and afraid that the Medicare program, because of some of the publicity surrounding the Medicare program with people hearing things about formularies and donut holes I think that some

beneficiaries fear the Medicare drug program and believes, that the PAAD program will go away if there's a Medicare drug program. And the 350 letters that we've received actually -- most of which I individually read -- was more a matter of fear. And some of the people who called us first-- Anybody that's called us first and told us that they're thinking of opting out -- our hot-line operators have been able to convince that there won't be any disadvantage to this. It's okay; you can let us handle it for you. The 350 didn't call first, and are just afraid.

ASSEMBLYMAN CHIAPPONE: Once you opt out, are you permitted to come back in?

ASSISTANT COMMISSIONER MASON: Yes.

ASSEMBLYMAN CHIAPPONE: You are?

ASSISTANT COMMISSIONER MASON: Yes.

ASSEMBLYMAN CHIAPPONE: And my final question is, in regards to the 10 percent to 25 percent savings on prescription drugs, is there a formula that determines the percentage of savings on specific drugs? How is that come to?

ASSISTANT COMMISSIONER MASON: That's really determined by the individual discount cards -- a lot based on what type of rebates they were able to get from the drug manufacturers.

ASSEMBLYMAN CHIAPPONE: Thank you.

Thank you, Madam Chairman.

ASSEMBLYWOMAN POU: Thank you, Assemblyman.

Assemblyman Gregg.

ASSEMBLYMAN GREGG: Thank you, Madam Chair.

Commissioner, I've been around this House for 11 years. I don't think I've had such positive testimony. I'm pretty impressed.

ASSEMBLYMAN GUSCIORA: We're a positive Committee.
(laughter)

ASSEMBLYMAN GREGG: Well, it's good. We were sitting here in the Federal Relations Committee, Mr. Chair, about nine months ago, and I think you were in front of it and testifying to some of your concerns, or perhaps worries, that things might not be so seamless. And it appears that they have been seamless.

ASSISTANT COMMISSIONER MASON: Yes. When I was here in February, we did not know at that point that we would have automatic enrollment. We found that out later in the Spring.

ASSEMBLYMAN GREGG: So I think it's a good day for New Jersey.

ASSISTANT COMMISSIONER MASON: Yes.

ASSEMBLYMAN GREGG: It appears from your testimony that it's worked smoothly. Your office has done a great job. Everybody seems to be getting more benefits or, at least, equal to what they had before. New people are getting drug benefits that didn't have them before. People with higher incomes are getting benefits that didn't have them before. So the program is working well right now, and you have a couple of concerns. And I do want to deal with those because it appears, up until today, New Jersey should be very happy. In fact, we were the best prior to the enactment of the Federal law. It has left us even better after enactment of the Federal law, and I think that's a compliment, as Assemblyman Pennacchio said, to you and your staff, as well as it is to the administration down in Washington for having the vision to provide these services for us.

You mentioned you want the next step to be seamless, and that seems to make a lot of sense. So these folks that have already begun to be

committed to the first program will seamlessly move into the second program, which will save New Jersey more money and give us more opportunities to provide better services. You mentioned Senator Grassley, who is not one of ours in New Jersey, and he had a legal concern. Could you explain that to the Committee so we understand, perhaps, where he's coming from, and maybe there's something we can do as a Legislature to get to our senators or our representatives or our legal minds to find out if that can be fixed?

ASSISTANT COMMISSIONER MASON: Yes. Senator Grassley has a legal opinion that indicates that if the state pharmacy assistance programs were to automatically enroll all their beneficiaries in one preferred provider -- the way we did the discount card -- that it would be a violation of the anti-discrimination clause that's in the Medicare drug program. And that clause says that in order for the state pharmacy assistance benefits to count towards the out-of-pocket costs -- so that what we pay for our beneficiaries would count towards the out-of-pocket costs, enabling our beneficiaries to qualify for the catastrophic coverage for people that have high drug costs -- we cannot steer beneficiaries into one preferred plan. And in fact, if we do that, that we would be violating the anti-discrimination provisions, and then we would not be considered a SPAP, as they call it -- state pharmacy assistance program -- to CMS, and our costs would not count towards the out-of-pocket costs.

Now, we actually have two legal opinions that we've obtained stating that the Medicare Modernization Act does allow for automatic enrollment, and that if we allowed our beneficiaries to opt out of the automatic enrollment process, as we did with the discount card, that we were still providing choice. I think the bottom line is that the Medicare drug program was to be voluntary and allowed for choice. What we lobbied and argued to CMS, in the past, is that when the State program is totally wrapping around benefits, as we

did with the Medicare drug program, the issue of choice becomes moot for our population, because they're not going to be disadvantaged in either way, depending on which plan they choose. And in fact, we would, through a RFP process, be identifying a plan that we believe would be in the best position to merge and coordinate with our program. So we have two legal opinions to counteract the legal opinion that Senator Grassley obtained, and would be happy to provide, through the Chair, those legal opinions for this Committee.

ASSEMBLYMAN GREGG: I go two to one, I guess we win. Get a third.

Yes, I would hope that both Chair people would get that available for the members of the Committee. Again, that's the last of my questioning.

I want to thank you for your hard work; and New Jersey seems to be better off today than they were nine months ago. I think that's a great thing from a standpoint of all the folks getting better medical services.

So thank you Mr. and Mrs. Chairman.

ASSEMBLYWOMAN POU: Thank you.

Before we -- and again, I know that you've been extremely helpful and you're been testifying for quite some time. I want to follow up on something that Assemblyman Gregg just talked about. Does the Department envision any disadvantage towards the new program, that we're now talking about, in addressing the most neediest population -- senior citizen population -- of our state? Is there a disadvantage to that population as a result of this change?

ASSISTANT COMMISSIONER MASON: Again, I would defer to the Department of Human Services. But certainly, there's some concern for the dual-eligible population that--

ASSEMBLYWOMAN POU: That's exactly what I'm referring to.

ASSISTANT COMMISSIONER MASON: --the dual-eligible population will no longer be receiving Medicaid prescription drug coverage. They're moved over to the Medicare program. And actually, as of January 1, 2006, if they did not pick a plan -- they have between November 15 and January 1, 2006, to pick which prescription drug plan they would enroll in. And we just received a decision this week that CMS will then randomly assign them to a prescription drug program as of January 2006. So certainly -- I know nationally there is some concern about the neediest population in the states, in all the states, going through that process and moving over from having their prescriptions covered through Medicaid to these new plans.

ASSEMBLYWOMAN POU: Thank you so very much, Assistant Commissioner. I really appreciate your time, your information, and your insight on this. I think your testimony was extremely helpful and informative to all the members here. Again, I'd like to thank you for taking the time being with us.

ASSISTANT COMMISSIONER MASON: Thank you.

Happy Thanksgiving.

ASSEMBLYWOMAN POU: Thank you. Same to you and your family.

I'd like to ask for Kimberley Fox from the Rutgers Center for State Health Policy. Kimberley, if you could come forward? Thank you, and good morning to you.

KIMBERLEY FOX: Thank you. Thank you for inviting me here today. I'm afraid I didn't get to hear Kathy's testimony before I brought mine up, so you will hear some redundancy in the testimony. But I just wanted to say good morning, Mr. Chairman, Madam Chairman, and the Committee members, and thank you for asking me to speak to you this morning, to share some insights from the work that the Rutgers Center for State Health Policy has been

conducting on the impact of the Medicare Part D drug benefit on state pharmacy assistance programs. I'm bringing to you more of a national perspective, because that's the nature of our work. We've been really talking to states across the country about what they're doing.

My name is Kimberley Fox, and I'm a Senior Policy Analyst at the Center for State Health Policy. With support from the Commonwealth Fund over the past three years, CSHP has undertaken a study of state pharmacy assistance programs, including the PAAD program in New Jersey, as one example, to assess best practices and lessons learned that might inform the design and implementation of the Medicare prescription drug benefit. As part of this study, we have conducted annual surveys, case studies and, most recently, telephone interviews with SPAP directors -- I'm sorry, SPAP directors is referring/meaning state pharmacy assistance program directors -- in 17 states, on their plans to coordinate with the new Medicare drug benefit. We have already issued a number of reports, links to which I will make available to the Committee staff. My testimony draws from this research, as well as discussions we have had with states on Medicare Part D implementation issues, during an invitational summit that we hosted in the Fall, for SPAP directors and Medicaid directors.

The Medicare Part D benefit represents the most significant change to the Medicare program since its inception in 1965, and will provide a new benefit to many Medicare beneficiaries that previously had no coverage. It also represents a considerable challenge for state programs, both Medicaid and state pharmacy assistance programs, that have provided critical gap-filling pharmacy coverage in lieu of a Medicare pharmacy benefit.

There are significant differences between the new Part D drug benefit and those that are currently available through the SPAPs, and the states

are in the process of determining whether to reconfigure their benefits to fill the gaps in coverage under Medicare Part D, or discontinue their programs. Similarly, while Medicaid drug coverage officially ends effective January 1, 2006, states are also in the process of deciding whether to wrap around some of the limits in the Part D benefit for this group. In this testimony, I will highlight the potential gaps in coverage, voluntary enrollment concerns, and lessons from the Medicare discount card experience -- some of which you've already heard from Kathy -- and states' plans for wrapping around Part D coverage, and related issues and challenges.

SPAPs currently serve approximately 1.3 million enrollees in 23 states. The design of these programs varies considerably across states in terms of eligibility, benefit design, and cost sharing. And it's far too complex to describe each one in detail. But on average, the SPAPs serve people with income up to 220 percent of Federal poverty level, who are not required to meet an asset test. Only two states currently require an asset test.

A principle challenge for the SPAPs will be addressing prescription drug affordability for the near poor, above 150 percent of the Federal poverty level, and those with some assets who are eligible for the basic Part D benefit, but ineligible for the generous Part D low-income subsidies. For these enrollees, who represent as many as half the enrollees in some state programs, the states must decide whether to wrap around all or some portion of the Part D premiums, deductibles, and coinsurance before, during, and after the donut hole that exists for beneficiaries that have prescription drug costs above \$2,250, but less than \$5,100.

Under the Part D regulations, state pharmacy assistance programs are allowed to supplement Part D premiums and cost sharing. In fact, the MMA appears to encourage SPAPs to help beneficiaries during the donut hole

period, because -- unlike other third-party insurers, as Kathy indicated -- spending by qualifying SPAPs can count toward a Part D enrollee's true out-of-pocket costs, thereby triggering the Medicare catastrophic benefit much sooner. Thus, SPAPs are considering the extent to which they should help enrollees fill this gap in coverage.

While Part D low-income subsidy cost sharing for SPAP enrollees who have incomes under 150 percent of poverty and few assets are generally equivalent or better than that provided by the SPAPs, they are still concerned about maintaining access to drug coverage in this group. The Medicare benefit will be administered by multiple private companies that are allowed to utilize cost-containment methods that most SPAPs are not currently using. For example, prescription drug plans are allowed to use closed or restricted formularies that may limit the coverage to only two drugs per class or have higher cost sharing for nonpreferred, off-formulary drugs. In contrast, SPAPs -- such as that in New Jersey -- generally have open formularies, meaning that enrollees have access to most drugs that have been FDA approved for which the state has obtained a manufacturer rebate. Thus, depending on the formulary of the specific plan selected, SPAP enrollees may no longer have access to certain drugs that are covered under their state program. The issue of covering off-formulary drugs is further complicated by the disallowance of counting spending toward the calculation of true out-of-pocket costs.

In the testimony, I also just provided a table that you should all know at this point, but basically describes the benefit. And it shows how each of the separate low-income subsidy groups are divided in terms of their cost-sharing requirements.

PDPs may also have more limited pharmacy networks than SPAPs. While the Medicare benefit has minimum geographical standards for pharmacy

coverage that the PDPs must meet, it is unlikely that the PDPs in a region will have the same coverage that is available in most SPAPs, which average around 95 to 100 percent of pharmacies in the state.

Limited formularies and pharmacy networks will similarly affect Medicaid beneficiaries, who currently have coverage for most drugs at most pharmacies in their state. In addition, Medicaid beneficiaries will be required to pay a \$1 to \$3 copayment for their drugs, which is not currently required in most state Medicaid programs.

A report released by the Kaiser Family Foundation yesterday actually did indicate that an estimated two million Medicaid recipients will face higher costs as a result of this copayment increase alone. It didn't factor in the formulary costs.

In terms of voluntary enrollment concerns and lessons from the discount card, to the extent that individuals currently enrolled in SPAPs enroll in Part D, there will be savings for state programs, as Kathy indicated. However, unless the State mandates enrollment in Part D, there is no guarantee that SPAP enrollees will voluntarily enroll. During the Medicare interim discount card period, only two states, Connecticut and Maine, passed legislation making Part D enrollment mandatory in order to qualify for state supplemental pharmacy programs. The remaining states left enrollment voluntary, but facilitated enrollment for their enrollees with incomes below 135 percent of Federal poverty and eligible for transitional assistance by using a preferred discount card, and autoenrolling their members into this preferred plan, as was done in New Jersey. The fact that this option was available to them, obviously, influenced the states in terms of whether they decided to mandate or not. The states utilizing the preferred card and autoenrollment approach were able to enroll the vast majority of their members and have yielded considerable savings.

Again, Kathy has already recounted with you New Jersey's experience. And as she indicated, approximately 80 percent -- actually this is a different 80 percent -- 80 percent of SPAP enrollees that were eligible for transitional assistance across the states were automatically enrolled through this method. In contrast, states that autoenrolled their members in multiple plans or that left enrollment voluntary had much lower enrollment rates.

However, under the current draft Part D regulations, SPAPs are not allowed to work with a preferred PDP or autoenroll their members into a preferred plan -- again, I feel like I'm repeating myself, as Kathy indicated this -- if they want to be qualified as a SPAP and have their expenditures count toward the TrOOP. While several individual states and the SPAP Transition Commission, established under the MMA, have submitted comments on the draft regulations recommending that states be allowed to use a preferred PDP, it is unclear whether this will be changed in the final regulations. Working with multiple PDPs will increase the administrative cost and also limit the states' ability to facilitate enrollment, which may result in lower enrollment rates, based on the discount card experience. It will also link the states' ability to negotiate with PDPs to get a benefit that is most similar to what they're currently offering.

Furthermore, the greatest savings to the states under Part D benefit will come from the low-income subsidies. As indicated earlier, like New Jersey, most states do not require an asset test for their state programs. Collecting this personal and confidential information from enrollees will be a challenge. Under the draft regulations, eligibility for the low-income subsidies will be determined either by the Social Security Administration or the state Medicaid agencies. For SPAPs that are managed by departments other than the Medicaid agency, conducting eligibility determination through Medicaid may be a further deterrent for SPAP enrollees, and some have argued that the SPAP be allowed to

determine Part D subsidy eligibility along with the Medicaid agency, as has New Jersey. Given that the Part D benefit has different eligibility rules than those required for dual-eligibles, and that the Medicaid agency is required to screen for other low-income benefits, state Medicaid agencies are also concerned about the increased administrative costs required to modify their existing eligibility systems and train and hire personnel to accommodate these new requirements, as well as increased costs from expanded enrollment in the Medicaid program.

State Medicaid programs also have concerns about the voluntary nature of enrollment in Part D. The draft Part D regulations require that dual-eligibles will be autoenrolled by May 15, 2006, if they do not voluntarily enroll in the prescription drug plan. The auto enrollment process is not well defined in the current regs, and it is unclear to what extent current drug needs will be taken into consideration in the assignment process. Medicaid enrollees also have the opportunity to opt out, and may mistakenly decide to do so assuming that they would still be able to get coverage through Medicaid. States will either be left paying the full cost of prescription drug coverage for duals who opt out of Medicare, or these individuals will be left with no coverage at all. In addition, states have raised concern about the potential gap in coverage for duals whose Medicaid coverage ends on January 1, 2006, but who may not be enrolled until May. As Kathy indicated, the recent decision by the CMS Administrator, Mark McClellan, to autoenroll dual-eligibles by December 31, obviates the potential gap in coverage, but they will still be randomly assigned to plans. So that issue is still out there. In addition, it's a pretty tight time line, I should just say, that would require 6.4 million Medicaid beneficiaries to be autoenrolled in a six-week period. So we turned a lot of people.

ASSEMBLYWOMAN POU: Kimberley?

MS. FOX: Yes.

ASSEMBLYWOMAN POU: Let me just ask you a question. In your earlier statement, you mentioned that the autoenrollment process -- you've now went on to further indicate that the states will either be left paying the full cost of the prescription drug coverage for duals or for opt-out-of-Medicare, or these individuals will be left with no coverage at all. Doesn't that indicate to us, then, that if the autoenrollment process is one that does not provide a program or cover the type of prescription that that particular senior citizen is required to have, that person will then be left without any kind of coverage? Is that what would happen in this particular case?

MS. FOX: This is in the case of Medicaid.

ASSEMBLYWOMAN POU: Right.

MS. FOX: In the case of Medicaid, the Medicaid benefit ends effective January 1, 2006. The states may choose to maintain a benefit, but it would not be eligible for Federal matching funds. So to the degree that if the State didn't choose to do that-- If people are autoenrolled, and they can voluntarily opt out, they could potentially go without coverage.

ASSEMBLYWOMAN POU: And isn't it then true that, again based on your testimony that you made reference, that from my earlier comment or question to the Assistant Commissioner, that Medicaid beneficiaries-- Based on your testimony right now, you make reference that Medicaid beneficiaries will be required to pay \$1 to \$3 copay for their drugs, which is not currently required in most states' Medicaid program. Are we now not asking the poorest of the poorest community to have to pay for something that they now are receiving the Medicaid coverage for?

MS. FOX: Some states have a current copayment. I believe the State of New Jersey does not. So they would have to pay a \$1 to \$3 copayment that they did not previously have to pay.

ASSEMBLYWOMAN POU: Going back to the autoenrollment process, the autoenrollment process may or may not provide them with the kind of prescription coverage under the Medicaid program. So not only are they now required to pay additional costs, but they may not necessarily have the necessary coverage for the type of prescription that may not be covered under this automatic enrollment process, or program, that they may be enrolled in. Is that not true?

MS. FOX: I'm not sure I understand the question.

ASSEMBLYMAN GUSCIORA: I can help. Say a Medicaid recipient is on thyroid medication, gets automatically enrolled into a program that doesn't cover thyroid medication, that person then would be out of luck.

MS. FOX: Well, I think that there's a concern on the part of states that they'll be some degree of, sort of, control over -- that the plans that the people go into reflect their medical needs. I think that's the issue.

ASSEMBLYMAN GUSCIORA: But under automatic, you said that they would be randomly assigned.

MS. FOX: Exactly. Under the current plan.

ASSEMBLYMAN GUSCIORA: So they could be randomly assigned to a program that doesn't cover thyroid medication.

MS. FOX: If the thyroid medication didn't fall into one of the specific drug categories and classes that will be under the U.S. pharmacy standard guidelines, but-- So it all gets to what is going to be--

ASSEMBLYMAN GUSCIORA: Even psychiatric drugs or something that -- a combination where this Medicaid recipient is taking -- he or she gets automatically enrolled into a random company that may or may not cover their whole series of drugs that they need to take.

MS. FOX: Yes, that is a possible problem.

ASSEMBLYWOMAN POU: Thank you.

I'm sorry. I didn't mean to interrupt your testimony. But I do think that -- just so that we're not going too far beyond your testimony, and not being able to refer back to it. So thank you. If you'd like to continue, please.

ASSEMBLYMAN GUSCIORA: Assemblyman Pennacchio, actually, has a question.

MS. FOX: I actually, just -- I mean, what I wanted to tell you was in terms of what states are considering, in terms of wrap around. I would only say they aren't much further along than New Jersey. The MMA requires Part D prescription drug plans to coordinate benefits with SPAPs that choose to provide supplemental financial assistance for the purchase or provision of supplemental prescription drug coverage or benefits, on behalf of Part D eligible individuals, and which offer the same benefit regardless of the Part D plan in which the individual is enrolled. States can either opt to coordinate benefits with the PDPs available in their region, or pay a lump sum to the private plans to provide supplemental coverage on the states' behalf.

Based on our interviews, in May and June of 2004, with SPAP directors in the 17 states, the vast majority of states had plans to continue to provide their supplemental coverage in some form, much as you do in New Jersey. Only Kansas and Wyoming had definitive plans to stop providing prescription drug coverage for Medicare beneficiaries in 2006. However, as these interviews were conducted prior to the release of the Part D benefit, it is possible that some states with smaller programs have decided to end their programs.

Most states, especially those with larger programs, were still in the preliminary stages of defining how they would wrap around the Medicare Part D benefit, focusing most of their attention, as Kathy indicated, on coordinating

the interim Medicare discount cards. States were considering a variety of options, including paying all or a portion of the Part D premiums, wrapping around the cost share to the current state coverage, providing coverage for beneficiaries affected by the donut hole, and wrapping around the formularies or pharmacy networks. Only the state of Missouri had a specific proposal: to restructure its SPAP to be a donut hole supplemental plan for Medicare low-income beneficiaries up to 200 percent of poverty. And I should indicate that's partially because their existing benefit was really less generous than the basic Medicare Part D benefit, for the most part, except for the donut hole. And even that did not pass in that legislative session, but will be reintroduced this session. Few states had considered the lump sum payment option when we had spoken to them.

In terms of looking ahead, many of the states are in a holding pattern, in terms of deciding how to wrap around the Medicare benefit, largely because the details of the benefit are still unknown. As Part D regulations are finalized and as the PDP plans emerge, states will have a better understanding of the potential gaps in coverage under Part D. The decisions related to what classes of drugs must be covered under the Part D formularies, which are yet to be made, will have a considerable impact on whether states pursue this course. Also, decisions about whether SPAPs will be allowed to work with a preferred plan and autoenroll their members, or whether they must work with multiple plans, will directly affect the level of SPAP savings, which in turn will affect the degree to which they choose to wrap around the benefit.

Some key decisions that states are likely to face in 2005, will include whether to mandate participation in Medicare Part D and the low-income subsidies as a condition of SPAP eligibility; whether to work with a preferred plan and autoenroll, if this is allowed in the final regulations; and

passing legislation to facilitate this process if necessary, and deciding what to wrap around and for whom. I'm sorry to be somewhat vague, but it's also just because I think states are in a position of really trying to decide how to move forward in a kind of constantly changing environment.

That concludes my testimony. I am happy to take any questions from the Committee at this time.

ASSEMBLYWOMAN POU: Thank you so very much, Ms. Fox.
Assemblywoman Voss.

ASSEMBLYWOMAN VOSS: It seems to me, from the testimonies that we've heard this morning, that if the State had plans that were being very beneficial to the population of this state, would they have to go into this Federal plan, or would it sometimes be to the advantage of the people not to get involved in this?

MS. FOX: The states that have state pharmacy assistance programs technically could maintain their programs on their own, if they chose to do so. Obviously, the state -- most of the state programs, like the one in New Jersey, is state-only funded, and so they are certainly interested in maximizing the Federal funds to the degree that they can.

ASSEMBLYWOMAN POU: Thank you.
Assemblyman Pennacchio.

ASSEMBLYMAN PENNACCHIO: Thank you, Madam Chairwoman.

We had expressed some of the concerns that you're raising now, going back in February. We were assured by your representative of the administration that we would be able to supplement some of these little mini-donut holes, such as the copays for Medicaid and things like that. Is it correct to say that if we -- even if we can't do it with direct Federal moneys, the

fact that we will have \$2.8 billion estimated coming in within the next 10 years, that could free up some of the moneys that we're currently using for PAAD, for Senior Gold, and use those moneys to supplement, to eliminate the copay for Medicaid and to do other things like that?

MS. FOX: That's certainly a choice, an option available to the Legislature--

ASSEMBLYMAN PENNACCHIO: Right. And you said--

ASSEMBLYWOMAN POU: Assemblyman, I just need to interrupt you for just a moment. I think there needs to be some clarity. There is not any of-- You've made reference to it twice already in terms of revenue stream and the \$2.8 billion. That money is not coming in, in terms of a revenue. We're only receiving that only as we use it. So I know you've made reference -- this is not revenue coming in.

ASSEMBLYMAN PENNACCHIO: This is estimated revenues coming in. It is estimated that we will get -- whoever did the actuarials -- \$280-something million a year for the next 10 years, based on our Medicare and Medicaid population, as it relates to this legislation, Madam Chairwoman.

ASSEMBLYWOMAN POU: It's my understanding that this is not a revenue, that we are only being-- It's only moneys that is being provided to us as a reduction in cost whenever we're using it. It's not money that we have and access. You're using the term revenue as if these are funds that we actually have right now.

ASSEMBLYMAN PENNACCHIO: Right. But out of the \$600 million -- and perhaps, Chairwoman, you can explain it to me. Currently, we're spending \$600 million for PAAD and Senior Gold. Is it safe to say that we will get \$280 million, or something like that, reimbursed if we did nothing for those programs?

ASSEMBLYWOMAN POU: No, of course not. We will only get reimbursed for the return of whatever programs or services that we're providing. We don't have the \$2 billion revenue, that you make reference to, within our budget, our Treasury.

ASSEMBLYMAN PENNACCHIO: See, then I'm, with all due respect, I'm totally confused. We have \$600 million a year that we're spending on prescriptions to senior citizens in the state -- PAAD and Senior Gold. If we did nothing and we just used those programs, we're getting nothing at all -- reimbursement from the Federal Government for those programs?

MS. FOX: If your beneficiaries did not enroll in Medicare or the Medicare Part D benefit, you would not receive any savings. If they enrolled then, yes, you will offset your cost with whatever Federal benefits are available. In terms of states estimating their cost savings, I think that they're also -- even that is a little bit dicey at this point, in terms of coming up with a hard and fast number, because of some of the differences in terms of whether the preferred drug plan would be allowed, for example, which if you have to work with one plan, you are able to potentially select a plan that is more in line with your current benefit, and you're likely to have more cost savings. Whereas if you have to work with multiple plans, then you have to modify your benefit or, sort of, take whichever plan's benefit is around yours, which may reduce your level of savings. So I guess, all I'm saying is that the states have not been able to-- I would say very few states have come up with hard and fast estimates of cost savings.

ASSEMBLYMAN PENNACCHIO: So, through the Chair, what you just said is that if they opt to stay in the PAAD and Senior Gold, you're saying we're not going to get any grant money for those seniors in those two programs, if they stay in those programs?

MS. FOX: Actually, you already--

ASSEMBLYMAN PENNACCHIO: Because you're saying we have to, excuse me -- they have to opt out of those programs into one of the approved prescription programs.

MS. FOX: I just want to be clear. The grant money is separate and apart. I'm sorry, the grant money has been allotted to states that applied for it, and it's for the transition -- to pay for transitional assistance for people, from their current benefit and their SPAP to the Medicare Part D benefit. That's separate than what the State will get through cost savings in the future, to the degree that their enrollees enroll in Medicare Part D.

Did I answer your question?

ASSEMBLYMAN PENNACCHIO: Respectfully, you're saying that we will not get money for PAAD and Senior Gold, even though we're providing those prescription programs for seniors, once they -- unless they come out and enroll in the Medicare program?

MS. FOX: In order for state pharmacy assistance program enrollees and states to benefit from the Federal moneys available through Medicare Part D, the SPAP enrollees have to enroll in the Medicare Part D benefit and the low-income subsidies.

ASSEMBLYMAN PENNACCHIO: And through the Chair, none is that is wrapped around with PAAD or Senior Gold? We can't-- Is it or is it not? I assumed it was.

MS. FOX: I think Kathy testified as to what the State of New Jersey is specifically doing. But the SPAP can wrap around the Medicare benefit. All we're saying is that someone has to enroll in the Medicare Part D benefit, which is voluntary, in order for the State to then wrap around that benefit and to achieve cost savings.

ASSEMBLYMAN PENNACCHIO: Thank you.

ASSEMBLYWOMAN POU: Assemblyman, in order for us to receive funding-- Let me go back. In order for us to be able to implement this program, we have to literally -- the Federal Government is going to only give us money for us to be able to, in return, give them back -- pay back the Federal Government in order for us to then implement this program. So it's not as if the Federal Government is going to give us dollars in excess, in terms of a grant dollar program for us to operate and run this program. We, in fact, have to pay the Federal Government in order for this program to operate. So the revenue benefit is really going to be very limited in terms of what we're going to--

But I'd like to invite the Assistant Commissioner back to the podium, if you would please, to perhaps better explain what I'm talking about. In order for us to really engage in this, there's going to be a process in place. And that process will require for the State to implement a return of the funds back to the Federal Government. So they're really not paying us to operate this program.

Assistant Commissioner.

ASSISTANT COMMISSIONER MASON: The State is not receiving a subsidy from the Federal Government to continue to administer the program. The savings that states could receive would be if our beneficiaries continued to maintain their PAAD and Senior Gold benefits, but also enrolled in the Medicare prescription drug program, similar to the way we did the discount card. So they don't lose their PAAD benefits, they have both benefits. And what happens is, they use the Medicare program benefits first, and then use our plan as secondary coverage. And the way we save money is because the claim is first submitted for payment to the Federal Government, and then we become secondary coverage.

ASSEMBLYMAN PENNACCHIO: If I may, through the Chair, therefore those moneys that we would have spent initially on PAAD and Senior Gold now are freed up?

ASSISTANT COMMISSIONER MASON: There is a cost savings to the State, because we are now no longer paying in full--

ASSEMBLYMAN PENNACCHIO: Right.

ASSISTANT COMMISSIONER MASON: --for those prescription plans.

ASSEMBLYMAN PENNACCHIO: And those cost savings could be used to take care of those mini-donuts, take care of larger donuts to supplement, enhance, and enrich all these programs?

ASSISTANT COMMISSIONER MASON: How those moneys are spent--

ASSEMBLYMAN PENNACCHIO: Legislatively.

ASSISTANT COMMISSIONER MASON: --would be determined by the Legislature.

ASSEMBLYMAN PENNACCHIO: Thank you.

ASSEMBLYWOMAN POU: Assistant Commissioner, do we have any idea what that percentage of that savings would realize?

ASSISTANT COMMISSIONER MASON: Again, as Kim said, it would depend on-- We don't even know yet who will be the plans operating in New Jersey, what their formularies will be, or whether our beneficiaries will be automatically enrolled. So any of the savings projections are dependent on all those unknowns at this point. So we are really not in a position to be giving savings when we don't even know what the plans are.

ASSEMBLYWOMAN POU: So, technically, there may not be any savings, that we're aware of at this time, that indeed will be realized?

ASSISTANT COMMISSIONER MASON: The savings are only to the extent that our beneficiaries sign up for a plan. If they don't sign up for a plan, we wouldn't save.

ASSEMBLYWOMAN POU: Okay.

ASSEMBLYMAN GUSCIORA: I'd like to follow up. Before I asked how much our program was. It was 600 million. I believe we only got 33 million from the Feds this year. So it's not as if the Feds are going to pay for all \$600 million of our program. And on top of that, there's also the clawback provision that -- even any money that they do give us, we have to end up, in the end -- give back to the Feds to administer the program.

ASSISTANT COMMISSIONER MASON: That's right. And over 100,000 people on the PAAD program don't qualify for the low-income subsidies. They would have a deductible under the Medicare program. They would have a donut-hole gap. Therefore, those costs would continue to have to be paid by the PAAD program.

ASSEMBLYMAN GUSCIORA: Esteemed colleague, Mr. Gregg.

ASSEMBLYMAN GREGG: Thank you.

I just feel compelled to make sure we stay on track here a bit. I'm a bit confused to where the direction -- to where we're going. We've heard some excellent testimony. It's very clear to me -- the testimony was explicit -- that we have a program in place; the Assistant Commissioner explained. It's going to save \$90 million in expenditures over 18 months, which is about \$60 million a year if you were to back that in. That the PAAD program spends \$600 million a year, approximately. One could argue that today, as we speak, that the PAAD program is only costing us \$540 million in the year that we'll be utilizing the initial phase of this program. What happens in the future does seem to be questionable, because we don't know how many people will be into the new

program. And some of those cost savings in the future are now not specific and clear. But New Jersey has had a benefit already because of this program, and it's \$90 million. That has been testified to, and we should move forward on getting the rest of testimony done. If this is going to be arguing whether it's a good program or a bad program, I'm confused.

I think everybody is saying it's a great program, that people in New Jersey are better off. We're going to get more people enrolled in pharmaceutical assistance programs that have higher incomes, in the future. There may be issues of benefits we wish to give as a Legislature, whether it's to fill gaps or to change deductibles. That's the will of the Legislature. There are bills to do that. As we speak, one of them has cleared one of our committees already. We should be learning more and stop debating whether we're getting money. We're certainly having a better benefit for our folks, so we should be talking about how we can do that even better, and what New Jersey and the Legislature can do to help the process work in Washington, and communicate with our citizens the benefits that they have.

Thank you for that indulgence.

ASSEMBLYMAN GUSCIORA: Actually, I just wanted to follow up, and feel free to follow up on mine. The fact remains that there are -- the lowest of income are now going to have to shell out money, where before they didn't. So if you ask somebody with low income, they're not going to say that this is a better program. And it is my understanding that there are actually states that have said, "No, thank you very much. We don't want the Federal program." So that could even be in the realm of possibility.

I'm not here to criticize the program. I think what's done is done. It's here, but I think it behooves us to get all this information. Exactly what are going to be the benefits and the costs, and exactly how much we're going to

benefit. And we should have to consider that those who are in the lowest-income bracket are now going to have expenditures to pay, where before they did not have to pay -- shell out money.

ASSEMBLYMAN GREGG: Only perhaps. And I think that's what we've been hearing. That there are things that have occurred and are in place, and then there are things that haven't occurred yet. The lower-income people that you're speaking -- the Medicaid people may have to pay a deductible if--

ASSEMBLYMAN GUSCIORA: Do have to. No, they will.

ASSEMBLYWOMAN POU: No. No. No.

MS. FOX: They will have to pay a copayment.

ASSEMBLYMAN GREGG: Excuse me, a copay. Excuse me, I'm sorry, wrong term. They may have to, because the law--

ASSEMBLYWOMAN POU: No. They will have to.

ASSEMBLYMAN GREGG: Under the language today, they will not get Medicaid dollars for that. It does not preclude the State from picking up that cost that the Federal law is not going to pick up any more. So that is part of a big picture of things that, as we implement the Federal legislation on a statewide basis, we will have some give and take, some things we can improve or unimprove. I'm not saying it's not in the Federal law now. I'm saying that we have options, and we have already acted as a Legislature to fill that gap, because we think that's a good idea -- because New Jersey has a different benefit than some other states, and that will continue to happen.

One of the great things about New Jersey is we have the best pharmaceutical assistance program, so we're always going to continue to have to say what we might have to do to shuck and jive to make it always better. And this is one little detail that we've already addressed in the Legislature in the Committee; and I suspect that your House or your leaders will post that bill,

because it's a good thing. And I'm going to suspect that most of us are going to vote for that when it comes up. But by and large, we're still moving forward with a better system for our citizens under the Federal law. I don't think anybody here is going sit there and say, "Let's opt out and let's not take the benefits." So if this is going to be debate on nickel and diming, we can do it all day, Assemblyman. But I think we're far better off checking off the list of the things we need to fix, and work on fixing them.

ASSEMBLYWOMAN POU: Assemblyman--

ASSEMBLYMAN GUSCIORA: My only point is that we haven't made that determination about whether this is a better program. I think the facts will speak for themselves. And what I'd like to do is get all that information and then, after that, somebody should make the decision of whether that's better. But I don't think that determination has been made at this point, and it's not universal.

ASSEMBLYWOMAN POU: I'm sorry.

Gentlemen, we're going to continue. I'm not going to continue this debate. I think that my point earlier was, Assemblyman Gregg -- was that we needed to get some real clarification. Clarification in terms of the terms that were being used. The terms being that -- as revenue, which in fact is not revenue; the term of where some of the funding and the dollars were really placed. Based on the information that you've just provided us with, it would really not yield any savings to the State if were to-- That is something yet to be determined. We don't need to do that now. It is much too early.

Let us continue to listen to the testimony. Let us hear from everyone, the experts in the field, that can help us to come together with the types of programs and legislation that is needed.

Thank you very much, Ms. Fox. Thank you for your testimony.

I understand Assemblyman Chiappone has another question.

ASSEMBLYMAN CHIAPPONE: Yes.

ASSEMBLYWOMAN POU: Thank you.

ASSEMBLYMAN CHIAPPONE: In following up on the Chairpersons' comments, I'd like to know as a legislator, specifically, what the basis is for the Federal Government coming to their claim that we would save \$280 million a year, \$2.8 million (*sic*) over 10 years. I'd like to have the documentation, which the Federal Government comes to this basis. I'd like to be provided with any information that they've had in making this claim, Madam Chairperson.

ASSEMBLYWOMAN POU: Assemblyman, I think our purpose here today is to try to gather as much information as we can that, hopefully, will help to address and answer your question. So I'm going to ask that we continue our testimony then, and hopefully, we'll provide you with the kind of inside information you're referring to.

Ms. Fox, I just want to personally thank you very much for being here with us.

Sorry for the little digression here for just a moment. In the spirit of bipartisan effort, that happens every now and then, but it's all done with good things in mind, and everyone is well intended, I'm sure.

Your testimony was extremely helpful and informative. I am going to ask our members to really take a look at the information, because you've provided us with certain charts in your draft, and I think that's going to be important. I think these are the kind of things that are going to help us to determine what some of our options -- as we continue on to this program.

Thank you, again.

MS. FOX: Thank you. And if ever we can be of any help to the Committee in the future, let us know.

Have a happy holiday.

ASSEMBLYWOMAN POU: Thank you so very much.

Happy holidays to you, too.

I'm going to ask our next speakers, Sy Larsen and Doug Johnson, from the AARP, to please come forward.

Good morning, gentlemen.

S Y L A R S E N: Good morning. I'd like to thank the Committee for the opportunity to testify. Let me very briefly address two questions that I think have been raised, and that is to identify those parts of the law in which we feel that New Jersey could save money. And also to respond to the question, Madam Chairlady, you raised as how it will impact on our particular constituency.

As has been testified now, the State of New Jersey will save approximately \$90 million from this transition assistance program. That is the cards that people have now to buy drugs. Also, in Part D, as you move PAAD and Senior Gold into Part D, the State will be able to save money. The exact amount of money, as been testified, we simply don't know.

Also, there's a 28 percent clause in the bill. The bill states that any employer which has a prescription drug program which is equal to or better than that which is offered in the RX bill, that that state will be able to reimburse 28 percent of the cost of its plan. Now, that would affect the State health benefits plan as it relates to retirees. So that's another area where the State can save money, because the State is identified as an employer in the bill.

The other clause where the State will save money, has been testified to, is the clawback provision, in which the State will pay 90 percent for its

Medicaid dual-eligibles. And as the years go by, that figure of 90 percent will be reduced to about 75 percent. And the last area that the State will be able to save money is that the Federal Government has allocated, for these two years, 62.5 million for educational purposes, and I think New Jersey will avail itself of the opportunity to get some of that money.

Now, how will it impact on our constituency? And we do have some concerns in that area -- concerns which have been raised by the other two individuals that have testified, particularly when it comes to dual-eligibles. Dual-eligibles today, under New Jersey rules, do not have to pay anything. They don't have a copay for prescription drugs. But what's going to happen as the new law takes effect? These individuals, if they're under 100 percent Federal poverty level, will be paying \$1 and \$3 copay; or under 135 percent, they'll be paying \$2 and \$5. Well, when you think of the kind of money that these people earn, you're talking about people that are making 9,000, 10,000, 12,000, 13,000 a year. This has a tremendous impact on them. Not only is it the copay, it's for each individual drug. So an individual who is using two, three, four, five, six drugs will have to pay that copay.

Not only that, but the way the law reads is that these copays are indexed to drug inflation. That is, they're not indexed to the CPI, the Consumer Price Index. Now, the Consumer Price Index and the Social Security may be increased by 2 to 3 percent a year, but drug inflation, we know, is double digit. So these people are going to find themselves into a situation where the bill negatively impacts on their income stream, and they're going to be faced with really dire consequences.

We, therefore, urge the Legislature -- whether it's a question of regulations -- to cover this amount of money from the money that you're saving from other areas in that bill. In other words, no individual should find

themselves either with higher copays or less benefits than they had previously to this bill.

Secondly, of course, when it comes to PAAD and Senior Gold, again, we don't feel that any individual should be placed in a position where they will have either higher copays or less benefits. People should be made whole. Now there is one area that will affect the dual-eligibles, and one area, too, that will affect PAAD and Senior Gold. And that's the whole question of whether they will be able to get the prescriptions they need.

Now the AARP has always favored PDLs. That's preferred drug list or formularies. But we favor them as long as there are proper consumer protection for the individuals. When you have these new insurance plans coming into effect, we don't know what the appeals process is going to look like. And it may come where there may be a drug which an individual will not be able to get, and which their doctor feels is essential to their health. We feel that PAAD should be able to -- PAAD or Senior Gold should be able to pick up the cost of that particular drug.

DOUG JOHNSON: Thank you. I just will be very brief.

I just wanted to point out that AARP is ready, willing, and able to help the State, in any way possible, as we move towards -- I think November 15 is the beginning of enrollment, and to November 15, 2005 -- enrollment in Medicare Part D. The State is going to get \$22.6 million for an educational campaign to help people understand the Medicare drug benefit Part D, and AARP would certainly welcome the opportunity to work with the State on that, and educating the public and helping them understand it. You are going to be confronted with some tough decisions.

AARP also would support automatic enrollment in Medicare Part D. But I must tell you, as you have heard already, we're not optimistic that

that's going to be allowed, as it was allowed for the drug discount card. But certainly that should be everyone's top priority -- in trying to make it possible to talk CMS into making it possible for states like New Jersey to automatically enroll into a preferred provider of Medicare Part D. That way you would virtually guarantee substantial savings that could then be used to fill in the gaps, which there are quite a few, in the Medicare drug benefit program.

And AARP also has a lot of educational materials that we provide to our members. We have 1.3 million members in the state. I would love to provide copies of this document, which explains the Medicare Part D benefit to any legislator, staff, or your constituents. Please do contact us.

Last but not least, I do want to emphasize the dual-eligible issue. We are concerned about that, but you have a choice to make. Do you want to use the savings to pay for these increased costs on the dual-eligibles? And AARP's position is that the State should pick up that cost, because you are going to be saving money if you enroll people in Medicare Part D, and the dual-eligible individuals and the PAAD beneficiary individuals should be held harmless. And that is AARP's bottom line in terms of what the Legislature is confronted with.

Thank you very much.

ASSEMBLYWOMAN POU: Thank you very much, gentlemen.

ASSEMBLYMAN GUSCIORA: I just wanted to thank Sy, particularly, for coming, because I've known him. I've worked with him. And he's truly part of the senior truth squad. And you continuously amaze me, of how knowledgeable you are and lucid in the testimony. So I do congratulate you for coming here.

One of the striking parts of your testimony is, I could see somebody who is living below or at the poverty line making less than \$9,000 a year -- if

they have to have eight or nine prescriptions and pay \$1 to \$5 per prescription, that's a heck of a lot of their disposal income that could probably just be eaten up. So especially since this is the highest to house somebody, in this state -- we're probably the highest in the nation as it is. Most of that money is eaten up in housing, and then food, and then to pay for a copay -- that's a heck of a thing that we're doing to those on low income. So I do hope that we do utilize the savings to make everyone whole under this program, and not penalize someone just simply for just being low income.

MR. LARSON: Well, thank you very much.

ASSEMBLYWOMAN POU: Thank you.

Our next speaker is Michael John (*sic*) O'Brien, from the Pharmaceutical Research and Manufacturers of America.

Welcome, Mr. O'Brien.

JOHN MICHAEL O'BRIEN, Pharm.D.: Thank you very much.

Thank you, Madam Chair. Thank you, Mr. Chairman, and members of the Committee. My name is John O'Brien, and I am here on behalf of the Pharmaceutical Research and Manufacturers of America. PHRMA represents the research-based brand name manufacturers of prescription drugs, many of which are proud to call New Jersey their home. I also appreciate the opportunity to be here, because I'm also a doctor of pharmacy and a graduate student in the Johns-Hopkins Bloomberg School of Public Health. So looking at programs that improve access, and equity, and outcomes, and costs is something that is very close to my heart.

I am excited that we've heard some positive testimony and some very good news this morning. The good news continues to come as it relates to the Medicare Modernization Act. Yesterday, the Kaiser Family Foundation had a briefing where they completed their analysis of what out-of-pocket spending

will be for Part D beneficiaries. What they discovered is that the average Part D beneficiary will receive a 38 percent reduction, but the people who are eligible for the low-income subsidies -- that is, beneficiaries under 150 percent of the Federal poverty line, or about 13,000 a year -- will receive an 83 percent reduction. That is, they'll pay 83 percent less for prescription drugs than they would have paid had this benefit not been passed.

Further good news, of course, is the fact that the New Jersey team, from a State preparation standpoint, has done, probably, the best job in the nation in preparing for the transition to not only transitional systems, but the Part D plan. And presumably, these figures are just part of the reason that AARP, of course, supported and was very helpful in the passage of this legislation, as well as the reasons that they had the kind things they had to say today. It's important to recognize that this bill is so new and this act has so many pieces that have yet to be promulgated under regulations -- the draft regulations are still out; and that many of these provisions will be implemented by private organizations, many of whom haven't even been created yet, and many of whom haven't even announced what their actual coverages are going to be. So not only is much of this very speculative, it's also a time for more of a cooperative information sharing -- almost an academic, scientific method approach -- as it is any ownership issues of any particular provision of the act.

The most important part that everyone has really been focusing on, on Part D, is preventing that dual-eligibles coverage gap. And we've heard the term *autoenrollment* a lot today, and it's very difficult for me to keep track of this in my mind. That autoenrollment will occur for dual-eligibles was a promise by the CMS Administrator, Dr. McClellan. That is a closed question. The open question refers to the beneficiaries who are not dual-eligibles, but enrolled in the other programs of PAAD, the Senior Gold, and may be eligible for low-income

subsidies. So, to the degree that the dual-eligibles will be autoenrolled and prevent that coverage gap, that has been at least publicly announced that it will be taken care of. And, of course, how the other piece shakes out remains to be seen. But given that it's gone to the benefit of the patient, to the benefit of the beneficiary for the last two autoenrollment questions, we can only hope that that good news will continue to come.

That was one of the most important things that every state was looking at -- is how do we prevent this coverage gap? Some other things that states should be looking at or considering -- and again, New Jersey is doing a great job in this -- maximizing the Federal payments. The 140,000 dual-eligibles in New Jersey who account for about 59 percent of State prescription drug spending, they will be taken care of. Their costs will be assumed by the Federal Government under the Part D provisions. The response to that, of course, is always, "Well, what about the clawback? What about the clawback?" And mathematically, the clawback will be a per beneficiary, per month calculation multiplied by the 90 percent -- trending down to 75 percent that Mr. Larson mentioned -- multiplied by the number of dual-eligible beneficiaries in the state.

The number that can't be changed in that equation is the amount of spending that occurred on those people. Now, someone said earlier that the clawback payment is based on what that spending would have been, when, in fact, the clawback payment is based on what spending actually was. The calculations -- the per capita expenditure calculations are based on October 1, 2003, spending. So that number can't change. A preferred drug list or any other attempt to reduce State spending won't change the per capita expenditure calculation under the Part D provisions.

What can change is the number of dual-eligibles in the state. And what many states are doing -- and again, New Jersey is leading the way on this -- is going through their roles and making sure who is defined as a dual-eligible is actually, indeed, a dual-eligible, and not receiving program assistance through some other similar or related program. Because it's a per beneficiary per month calculation, there are some eligibility questions. And this is tough for me to understand, but as it has been explained to me: If I apply for a new credit card, did I become a credit card customer on the day I signed the application, on the day that they receive the application, on the day I received the card in the mail, or the day that I first used the card? So those are some of the questions that are out there. And perhaps the most important thing that New Jersey can be doing right now, again, is minimizing their Federal payments and making sure that the clawback payment that is calculated is actually the best that the State can do.

Now, it has to be mathematically lower than what the spending is today. Because it's, admittedly, 90 percent. It's admittedly based on State share. So it's not the large number that everyone likes to quote on prescription drug spending. It's actually only the portion that the State is spending. And further, it's only for Part D covered drugs. So any medicines that are not included in the Part D provisions -- those moneys that were spent in October 1 of 2003 -- won't be included. And further, the number that's quoted will also be adjusted down for manufacturer rebates. So the money that New Jersey received from manufacturers in terms of rebate payments won't count against them in clawback payment calculations. So perhaps the most important thing that New Jersey can be doing now is minimizing their Federal obligations, or the reverse revenue sharing, as some are calling the clawback today.

On the opposite side of that coin, which is also just as important, is maximizing the Federal assistance. And we heard today how New Jersey is doing a great job of getting the SPAP dollars and getting the SHIP dollars, the State Health Insurance Partnership dollars. And again, as Mr. Larson attested to earlier, the importance of that retiree coverage -- and I know others will probably comment on this today -- but again, the ability to receive a 28 percent subsidy, or about \$1,330, as a maximum benefit per state retiree, just for keeping them in that program -- that's an annual payment back to the State, tax free, from the Federal Government. So recognizing that we have representatives here today from some departments -- again, making sure that statewide, from a benefits perspective, the impact of the MMA is being investigated.

One thing that many states are also doing is analyzing their cost-containment measures. Some states have had preferred drug lists in place, or some states have negotiated rebates based on the amount of drugs that are used. Other states are investigating or using disease management programs. What's interesting, as it relates to the Medicare Modernization Act, is that you're very tempted to say, "Well, dual-eligibles are responsible for 59 percent or 58.6 percent of New Jersey's drug spending, so we should multiply that by what our expenditures were." When, in fact, not only is that just a good start, it's important to remember that these patients are taking different types of medicines. Dual-eligibles are twice as likely to be on cardiovascular medicines than are nondual-eligibles. The reverse could be said for antibiotics. So looking at the medicines that they're going to be using and investigating how we can best help the patients who will remain in the Medicaid program -- correct -- because many patients will remain in the Medicaid program, and it's no longer going to look like what Medicaid looks like today. It will be children. It will be other transitional populations -- you know, pregnant women and others. So it's

important to look at, in any attempt or any discussion, how should New Jersey manage costs. It's important to recognize what the program will look like then, and anticipate what any change now -- how that would affect what that population might look like then. So analyzing any proposed cost containment approach is probably another important thing that the state already is and should continue to be doing.

And lastly, perhaps the most important thing is educating the beneficiaries. The MMA will be implemented. There will be no do overs. The election is over. Any changes or any complaints about the bill should be heard in Washington. At the State level, it's about making sure the State takes advantage of it, and making sure that the patients that the program was intended to help -- making sure they receive the help. Now, many of us have insurance plans that in November of every year we receive this packet, and we're asked to make the best decision in advance on to how we want our health benefits to come, and should we chose a large copay or a small copay, or what have you. Again, these beneficiaries will receive a welcome-to-Medicare-Part-D packet, the contents of which will be determined by a private entity. And the private entities can design the plan any way they want.

We've discussed a donut hole. Many of us are thinking about the little box that we saw in the newspaper, after it passed -- this is what the benefit is going to look like. And between 2,250 and 50,100, all your drugs are on your own. That's an actuarial model that, really, only the Part D plans are using to negotiate with each other and to negotiate with manufacturers. The only thing that we know about what a plan will look like, is that those who are over 150 percent of FPL are off the hook after they pay \$3,600 in true out-of-pocket spending. And we also know that state pharmacy assistance programs are one of, really, three people -- individuals, state pharmacy assistance programs, and

bonafide charities -- that are allowed to stand in the shoes of beneficiaries. Meaning, if the SPAP pays money to help a beneficiary -- through the donut hole, or to lower premiums, or to lower deductibles -- that money counts towards that beneficiary's true out-of-pocket spending to such an extent that you're actually helping that beneficiary get closer to the Federal reinsurance provisions, at which point the government picks up 95 percent of their costs.

So the standard coverage is defined as it has been graphically, which is 75 percent of your drugs will be covered up to this amount, and 95 will be covered after you reach \$3,600 in true out-of-pocket spending. How that will be implemented by the private plans, of course, remains to be seen.

And lastly, again, part of the education initiative or education efforts is making sure that people take advantage of the money that's available to them. These Kaiser slides floored me. A beneficiary who is below 100 percent of poverty -- if they sign up for the Part D plan, their maximum out-of-pocket spending, on an aggregate based on this study, will be \$90. The maximum that they'll likely pay, if they don't sign up -- and I average -- is \$943. So these are tremendous savings. And granted, a \$1, \$3 copayment, or a \$2, \$5 copayment for people above 135 percent of poverty is, indeed, a significant amount of money to someone who is on a limited income. However, because these are private plans, we don't know if they'll even be required to pay that yet. These will be competitions between private entities including pharmacies, to the degree that a pharmacy may say, "Well, in order to participate in this network, perhaps we won't require that." Or a PDP may say to a pharmacy, "If you help us reach more people, we won't hold you to that \$1, \$3."

Now, again, I can't speculate on the behavior of pharmacies or prescription drug plans, but nothing has been decided yet as to what that benefit will look like. And working with those who are able to define what the benefit

will look like is what's going on right now. And everyone is making sure that this benefit is what it was intended to be, which is an immediate helping hand, immediate transitional assistance, and a lasting, meaningful benefit to the patients who need it the most -- those below 100 percent of the poverty line; those below 150 percent of the poverty line; those eligible for low-income subsidies -- who will receive an 83 percent reduction in what they would have spent for prescription drugs. And again, helping the other patients -- those upwards of those figures -- take advantage of all the other help that's available -- the manufacturer discount programs, the patient assistance programs, as well as the projected, close to 40 percent, savings.

Approximately 24 percent of patients will make it to the donut hole. Of that 24 percent, only 11 percent will make it all the way through. So again, focusing on where the potential problem may arise from a benefit that hasn't been defined yet, that's really the number of people that we're talking about. The majority of the people -- tremendous benefit. The majority of people will never reach the donut hole or any gap in whatever the standard coverage actually looks like. But again, girding those people and helping them get through that individual coverage limit, or helping them reduce their premiums or reducing the deductibles, are just some of the things that the State may be able to do to help people in New Jersey who are eligible for Part D -- not only enroll in the benefit, not only take advantage of the benefit, but receive an additional benefit that supports the benefit.

So we appreciate the opportunity to be here, and the recognition that disease is the enemy, not this act or any particular industry. And we appreciate any opportunity that we have to help more patients receive help under the act.

Are there any questions about any of this?

ASSEMBLYWOMAN POU: Are there any questions from any of the members?

Assemblyman Chiappone.

ASSEMBLYMAN CHIAPPONE: Yes.

Thank you for your testimony.

Glancing through the Kaiser report, clearly though, one-fourth of the people -- 7.4 million people -- will have to pay an average of \$492 extra. In total, that's an addition of \$3.6 billion that a substantial amount of the population will have to pay. And then I heard you mention the word *good news*. Well, certainly, this is not good news to a fourth of the population. How do you suggest that we help these people who will have to now incur these out-of-pocket expenses?

DR. O'BRIEN: Well, without their report in front of me, as I understand it, that 7.9 million is a national number, and the \$492 that they'll have to pay extra, according to the report, also includes people who may not have coverage today. And that includes their premiums. So to say that people who don't have drug insurance today and aren't paying premiums and deductibles today, will have to pay more under a plan that requires premiums and deductibles, to me is a *res ipsa loquitur* -- it speaks for itself. It's not to reduce the importance of getting those people help. And again, by focusing on that 22 percent who will make it to the donut hole and looking at the degree to which New Jersey wants to help those people, designing ways to, perhaps, provide additional coverage through the donut hole is one potential strategy.

Now that \$492 number again, which is an average, corresponds to a nearly \$1,000 savings for the two-thirds of the patients who will receive a major reduction in spending. So I suppose, in summary, for many people the Modernization Act or the Part D benefit is a red carpet. For others, it's a carpet.

It's better than walking on a cold, hard floor, but it isn't everything that it could be. So looking at how the State can help and looking how bonafide charities can help make the benefit even better, perhaps, is where we should be focusing on. And again, that population is someone who needs that kind of help.

ASSEMBLYMAN CHIAPPONE: Was any part of the study broken up into state analysis?

DR. O'BRIEN: I did not see any state-by-state analysis of the report, so I can't really comment. But knowing the percentage of dual-eligibles and knowing how generous the PAAD and Senior Gold benefits are in this state, you're really on the right track of making sure that these people continue to receive a benefit that is as good as they have today.

ASSEMBLYMAN CHIAPPONE: Thank you.

ASSEMBLYWOMAN POU: Thank you, Assemblyman.

Actually, just based on -- if we used your numbers of 58-- I'm not doing this by any scientific manner of any sort. But if we just used that, in terms of the figures that you've showed, and just do the simple mathematics, the 58, we would probably -- can be as high as, not saying that it will be, but it could be as high as this 42 percent. Certainly lower than that if nationally we're at 25 percent of the people who would be affected in terms of the lower income level. But that's something that, as you've just mentioned, is still unknown to us. And there's a lot to be learned, and still a lot to look into, in terms of the amount of the population that, in fact, will be affected. But it could be as high as 42 percent, or lower, obviously.

Are there any other questions?

Yes. Chairman Gusciora.

ASSEMBLYMAN GUSCIORA: Doctor, I appreciate you coming down to us. It's great to have your expertise, particularly from the

pharmaceutical industry. One of the things that caught my eye in your testimony was the drug rebates from the companies and that it would not be calculated in the clawback formula. Could you tell us how the mechanism of the rebates work, and how we can make sure that we're looking out to make sure that we get those rebates back from the pharmaceutical industry?

DR. O'BRIEN: In calculating the per capita expenditures, it's tempting to look at, "Well, how much did this state spend on prescription drugs for Medicaid dual-eligibles?" And to assume, "Well, we're going to have to pay 90 percent back of that to the Federal Government." When, in fact, the pharmaceutical manufacturers, in 2002, paid 127 million rebates, under the over 90 provisions, and an additional 40 million in rebates under the CPI provisions. So to include that number in the clawback payment would be unfair. Now, all the regulations, or even the act, states is that the clawback payment will be adjusted for manufacturer rebates. So I can't predict how that will affect any future rebate programs or anything like that. But as it relates to calculating the clawback, it's important only to look at the state share of expenditures, which will only include Part D covered dispensed drugs and dispensing fees paid to pharmacies.

ASSEMBLYMAN GUSCIORA: Thank you.

ASSEMBLYWOMAN POU: Thank you so very much.

Are there any other questions for the Doctor? (no response)

Seeing none, I'd like to thank you, Doctor, for your testimony. We really appreciate it.

DR. O'BRIEN: Thank you, Madam Chair and Mr. Chairman.

ASSEMBLYMAN GUSCIORA: Thank you.

ASSEMBLYWOMAN POU: I just want to take a moment to find out if we have all the people in the audience that have signed up for testimony.

I'm going to ask -- I'm going to read out the names in the order that I have it in, and if you can just let me know that you're here.

Cathy Chin, Mental Health Association? I see Cathy.

Sue Gottesman? Okay, for the New Jersey Council on Developmental Disabilities.

Beverly Roberts from the Arc of New Jersey? Okay, Beverly.

Lowell Arye? Thank you. Alliance for the Betterment of Citizens.

And Alex DelPizzo, Healthcare Institute of New Jersey? Alex, thank you.

Okay. I'm going to ask, for the sake of trying to utilize our time a little more effectively or just better organized, I'm going to ask if Cathy Chin, Beverly Roberts and Lowell Arye, if you could please come up as a panel and maybe provide us with your testimony, so that we can do that in that manner. And then I'm going to ask if Sue Gottesman -- I know I'm killing your name, forgive me -- Alex DelPizzo, if you would come together as a panel? Okay. Thank you very much.

I think it's now afternoon. Good afternoon to you. Thank you so much for being here and providing us with your time and testimony.

Cathy, why don't we begin with your testimony, and we'll just go across. Okay.

C A T H Y C H I N: Good afternoon, Chairperson Pou, Chairperson Gusciora, and members of the Assembly Senior Issues and Federal Relations Committees. My name is Cathy Chin. I'm a legislative advocate for the Mental Health Association in New Jersey. Thank you for this opportunity to speak on an issue that is of very serious concern to mental health consumers.

I have witnessed all of you work very hard over the years to protect our most vulnerable here in the State of New Jersey, and their access to

prescription drug benefits. And I thank you for continuing to do what you have always done and what you believe in.

For over 140,000 dual-eligibles in the State of New Jersey, Medicaid prescription drug coverage will end when the new Medicare prescription drug coverage program begins. Drug coverage for dual-eligibles will shift from Medicaid to private Medicare prescription drug plans, and dual-eligibles will not have the choice to retain their Medicaid prescription drug coverage, instead of signing up for the Medicare prescription drug plan. Dual-eligibles have poorer health status and more extensive prescription drug needs than most other Medicare beneficiaries. Coverage of medically necessary drugs is particularly critical because most dual-eligibles are quite poor and thus unable to pay out of pocket for noncovered drugs. For these individuals, closed formularies and copayment obligations pose special risks. Both their ability to navigate an appeals process and afford needed drugs in the interim is limited. This could result in serious reductions in access and harmful disruptions in care. Additionally, under Medicare, if you are unable to pay for medications or the copayment, providers can deny medications, unlike under Medicaid.

The Mental Health Association in New Jersey is extremely concerned that the Part D drug benefit would likely cause harmful disruptions in care for dual-eligibles for which access to psychiatric medications is a critical component of community-based care. Most mental health consumers become dually-eligible by first being employed and then, perhaps, becoming ill, or perhaps their symptoms increase to such an extent that they have to leave their jobs; then they become poor, and then are eligible for Medicaid. So that's typically the journey for dual-eligibility for mental health consumers.

There is a high rate of mental illness among this segment of Medicare beneficiaries. According to Medpac, 38 percent of dual-eligibles have

cognitive or mental impairments. According to the New Jersey Department of Human Services, 22.2 percent of New Jersey's dual-eligibles are prescribed antipsychotics and 28.6 percent are prescribed antidepressants.

The issues for dual-eligibles: Right now in New Jersey, most mental health consumers who are dually-eligible choose, under Medicaid, to go under the Fee For Service Plan, for the simple reason that they have full access to all prescription drugs. Dual-eligibles, under the present plan, Medicare plan, may not have meaningful access to the full range of prescription drugs. In the draft regulations, the proposed classification for mental health drugs is badly flawed in grouping older medications, that are far inferior in terms of their efficacy and dangerous properties, with newer therapies that are more effective and have much more manageable side effects. Because these newer drugs are more expensive, grouping them together with the older medications will encourage health plans offering the Medicare drug benefit to cover only the older, less expensive drugs.

The proposed guidelines seem to have ignored an extensive body of knowledge regarding pharmacological treatment of mental illness. It does not appear that the guidelines' architects took into account the serious side effects of many psychotropic medications, the variability of individual response to these agents, and the reality that these drugs are not therapeutically interchangeable. Therapeutic substitution is highly inappropriate for this population given the many factors that treating physicians must take into account; the wide range and varying side effects; the variability of mental illnesses themselves, in terms of how they present themselves; and the noninterchangeability of many of these medications, given critical differences in mechanisms of action and how they affect brain chemistry.

I'll give you two examples. The antidepressants: The categorization that groups into a single class both the older tricyclics with reuptake inhibitors is deeply troubling. Tricyclics have very dangerous side effects and potential lethality in overdose. An overdose of as little as a seven-day supply of tricyclic can result in a potentially fatal cardiac arrhythmias. With suicide a major risk for those suffering from depression, the lethality of tricyclics in cases of overdose must be weighed heavily by physicians in determining the most suitable medication in an individual consumer.

The common grouping of tricyclics and SSRIs is not the only serious flaw in this category. Many of the reuptake inhibitors themselves have different mechanisms of action and should not be grouped into a single class. They affect brain chemistry in distinct ways, have singular side effects, and some evidence shows their effectiveness varies depending on the type of depression. They also differ in how long they remain in the body. A recent poll of Consumer Reports, with commentary by national experts, found that it is essential to have a wide choice of antidepressants, because most people need to try several before they find out what works, and no one can predict which one will.

The second serious one is antipsychotics. Newer, atypical antipsychotics have been shown to be effective and display fewer side effects. Older medications are not as effective. For instance, they do not alleviate the symptoms of apathy and withdrawal, which is very serious, because many of our consumers are out there trying to work. But even worse are the pervasive, uncomfortable, and symptoms-disabling, and dangerous side effects evident in an estimated 40 percent of patients, which include muscle spasms resulting in abnormal and usually painful body positions; tremors and muscle rigidity;

involuntary repetitive movements, often of the face, the mouth, or hands; and painful muscular restlessness, requiring the person to move constantly.

Nonetheless, even within the proposed class of atypicals, antipsychotics are less interchangeable than SSRIs. Research shows that different antipsychotic medications affect separate portions of the brain and affect the brain in very different ways. As a result, they have very clinical and side effects. With the very troubling side effects common in both older and newer generation antipsychotics, beneficiaries must have access to the full array of these medications to meet their individual needs. Limited access to appropriate medications can cause relapses and can impair consumers' ability to recover. Moreover, these policies may also impose a significant risk of death, since persons with depression and schizophrenia are at significant higher risk of suicide compared to the general population.

The second problem: Currently in New Jersey we have all worked hard to prevent the implementation of a prescription copay. I have inundated, over the past two years, many of the legislators telling them, showing them, from Kaiser Commission studies, etc., that it will negatively impact utilization rates. Under the Medicare provision, cost sharing and copayments for dual-eligibles may be unaffordable for low-income persons with mental illness who have extensive drug needs, and will impact utilization negatively.

It is my understanding that this group is not eligible for the low-income subsidy, which was referred to before in PAAD. I could be wrong, but I don't think that they are. For people whose monthly income already may be too low to adequately cover their mandatory expenses -- rent, food, and other basic necessities -- cost sharing can become an insurmountable burden. Mental health consumers who are dual-eligibles rely on several prescription drugs on an ongoing basis. For this group, cost sharing obligations could easily exceed \$25

to \$30 a month, a burden that could leave many to go without needed medications.

Thirdly, presently under the Medicaid laws if you go into a pharmacy and you ask for a prescription drug and you can't afford it, that pharmacist is not allowed to deny you coverage, so you can get the medication. No such law exists under Medicare. So withholding drugs for inability to pay cost sharing could lead to treatment interruptions. The absence of the Medicaid provision that ensures that low-income beneficiaries can receive their medications, even if they cannot pay their cost sharing raises, is serious concerns. Treatment interruptions for mental illness can lead to acute episodes requiring hospitalization.

And fourthly, we have a number of very serious concerns regarding provisions in the proposed regulations to allow Medicare drug plans to involuntarily disenroll beneficiaries for behavior that is disruptive, unruly, abusive, uncooperative, or threatening. These provisions create enormous opportunities for discrimination against individuals with mental illness. This standard would unfairly deny protection for beneficiaries who complied with medical advice, for example, by trying on an unformulary drug instead of the drug needed, and as a result experienced a bad reaction causing their disruptive behavior. It is patently unfair and discriminatory to deny protections for those whose allegedly disruptive behavior is a result of diminished mental capacity.

Moreover, this lower standard would impose unacceptable risks to the health and well-being of these beneficiaries, many of whom are likely to have very low incomes, with no way to access needed medications during the extended period when they would have no drug coverage as a result of being involuntarily disenrolled. Plans must be required. Those who are disenrolled

will suffer severe hardship, as they would not be allowed to enroll to another drug plan until the next annual enrollment period.

Finally, while it is impossible to predict definitively, prescription drug coverage will change for New Jersey's low-income dual-eligibles with uncertain implications for access. Interruptions and barriers to prescription drugs can be especially problematic for dual-eligibles suffering from serious and debilitating chronic illnesses, such as severe mental illness, HIV/AIDS, epilepsy, among others. It is critical that these very vulnerable beneficiaries receive coverage for the medications they need and are not harmed or made worse off.

MHANJ and a number of statewide advocacy organizations have begun to study this problem and are looking into the possibility of recommending that State policy makers address the gaps in protection between the existing Medicaid benefit and the new Medicare prescription drug coverage by providing a wrap around coverage for dual-eligibles. For instance, perhaps autoenrolling PAAD and our Medicaid dual-eligibles into Medicare, and then wrapping around with PAAD. And then I would also add that there, perhaps, could be a graduated cost sharing.

Thank you for giving serious consideration to this issue.

ASSEMBLYWOMAN POU: Thank you, Cathy.

I'm sorry. Mr. Lowell Arye.

LOWELL ARYE: My name is Lowell Arye.

ASSEMBLYWOMAN POU: Arye.

MR. ARYE: Yes.

I am the Executive Director of the Alliance for the Betterment of Citizens with Disabilities. We are a statewide organization that represents 13 member agencies that serve more than 8,000 people with developmental disabilities, and their families, in the state. Most of the individuals that my

agencies serve are people who are medically complex, have ambulation issues, require frequent monitoring and assistance with their daily needs -- and many of these people have significant problems with swallowing seizure disorders.

We appreciate the opportunity to discuss our concerns about the Medicare Prescription Drug Improvement Modernization Act. The most significant issue related to this frail population are the dual-eligibles. A critical test for the implementation of this new program will be whether or not dual-eligibles will be able to have their extensive, complex, and varying needs met through this program.

Who are the dual-eligibles? We've already heard that about 140,000 Medicaid beneficiaries in the state are also dually-eligible for Medicare. We have also heard that about 60 percent of the drug expenditures in Medicaid are specifically for this population. For people with developmental disabilities, the dual-eligibility issue is extremely important. About 50 percent or more of the nonelderly dual-eligibles qualify as dual-eligibles because of their parents' Social Security earnings. These individuals are called disabled adult children. These are individuals who may qualify for Social Security and Medicare upon the retirement, death, or disability of their insured parents. These individuals must meet the Social Security definitions for disability, which are the strictest in the world, and they must have been disabled prior to age 22.

According to the data from the Social Security Administration, more than 5,400 of those individuals who are DACs in New Jersey receive SSI and Social Security disability off of their parents' records. A significantly larger number -- and I couldn't find the number on Social Security's Website -- but as many as 30,000 to 40,000 more individuals are also going to qualify for Social Security for retirement or as survivors. In addition, many of these individuals, and we have 1,500, approximately, are also -- many of them are dually eligible

because the New Jersey Workability Program, which allows for individuals to continue to work and to be eligible for Medicaid. A significant portion of those individuals, more than 70 percent, are the mentally ill. These are people who both qualify under their own records for Medicare and Social Security, and also have SSI.

Our biggest concern is, will the dual-eligibles be able to receive their prescription drugs under this new program? We are really very concerned about the move to Medicare for Medicaid populations. We have one of the most extensive Medicaid programs in the country. And specifically, you all, and the Legislature and the administrations in the past, should be very proud of this program. Specifically, we cover almost all prescription drugs, and there are currently no formularies. And as Cathy has just said, there's also no copays. This is a really important piece. Unfortunately, now, we are going to have copays for this population. There will be formularies for this population. We are very concerned about issues of anti-seizure medications, antipsychotics that might not be included in the formularies under the Part D.

In addition, I'm not going to go into -- as well as what Cathy discussed about the issues of Medicaid loss, specifically related to -- that pharmacists basically have to allow someone to get their Medicaid prescription drugs, even if they don't have the ability to pay copays.

There are a number of challenges for enrolling people with dual-eligibles. Certainly the most recent statement by the CMS administrator, Mr. McClellan, with regards to the autoassignment, is an important first step for autoassignment. There's only one problem with it. We only have about six-and-a-half weeks from the time that they're going to have the Part D plans to the time of formal enrollment for the Medicare Part D for the dual-eligibles. That's a very small amount of time for people who -- many of them who have

significant problems themselves, and/or their families, to figure out what it is that -- what is the correct plan to go into. And if they're not putting into the correct plan, then they're going to be autoassigned.

There are financial impacts to New Jersey, specifically for this population. Certainly dual-eligibles are the folks who have some of the most medically complex needs in the state. And certainly the issue, as you heard from PHRMA -- with regards to the way in which the rebates are dealt with, will be "a savings." There's only one issue with regards to that, that you did not hear. For the DD population especially, we're talking about only half of the people in the DD population, not even, are currently going to be dually eligible. The same kinds of prescription drug needs for the rest of the DD population for Medicaid are not -- they're still going to get the prescription drugs and they're still going to have specific issues about the rebates. Unfortunately, the rebates are going to be a lot smaller, because there's going to be a much smaller percentage of the drugs that we're going to be using.

In addition, according to the Congressional Budget office, the elimination of Medicaid financed prescription drugs will reduce Medicaid spending, initially. Certainly, over a 10 year period, states will receive 85 percent -- will see that 85 percent of those savings are going to disappear. And that's according to the Congressional Budget office. There are several reasons for it: One is what many people call the *woodwork effect*. There will be a higher enrollment in Medicaid as people apply for the Part D low-income subsidies. More people will determine that they are now -- and the State will determine that they will be -- eligible for Medicaid, and so the other acute health-care needs and long-term care needs of this population will increase.

In addition, the State will have new administrative responsibilities for the program. In addition, the clawback payments -- although some people

have suggested that they are going to be savings -- may not be savings. Because as soon as you go from the State to the Federal Government, now there's no more money that they're having to pay for it, but they're going to have to continue at least for the next nine years up to 75 percent of payments back to the Federal Government.

What can we do here in the State of New Jersey? As Cathy said, we really need to take a look -- and the advocacy groups have started to band together to work on these issues and to look at assisting the State in minimizing the impact of Part D coverage. And we are interested in having the State work with us to explore wrap around for State PAAD and Senior Gold for this population. We also have to begin now to develop outreach enrollment efforts, specifically for this population. We must be fully prepared in November of 2005 -- that's just one year away -- to start to enroll this population. Unfortunately, a lot of the information we just don't have, and it's all dependent upon what happens when the new regs come out from the Federal Government. But we must begin now to plan and strategize, and we look forward to working with you all, as well as with the administration, to do that.

Thank you.

ASSEMBLYWOMAN POU: Thank you, Mr. Arye.

Ms. Roberts, Beverly Roberts.

BEVERLY ROBERTS: Yes, hi. I'm in full agreement with everything that Cathy Chin and Lowell Arye have just said, and I've tried to slash away parts of my testimony, because I know that this has been a long morning. It's a pleasure for me to be here, and I'm going to go through this as quickly as I can.

My name is Beverly Roberts. I'm the Director of a program at The Arc of New Jersey that's called Mainstreaming Medical Care. We're very, very

concerned about the impact that the Part D Medicare benefit is going to have for people with developmental disabilities in New Jersey who are dual-eligibles. Before I go into my comments, I just want to be very clear that we are very pleased at your proactive approach in having this Joint Hearing today -- that you truly are concerned about what should be done to fix the medication gaps -- and we're very appreciative.

I want to reemphasize that, although the public has been told and some other people have testified about improvements that will occur because of the Medicare Part D benefit, the reality is, it does just the opposite for people who are dual-eligibles in New Jersey. Now there are no formularies, there are no copays for our dual-eligibles. And that is not going to be the case when the Part D benefit goes into effect. This is something that has not been out there in the media at all, in terms of how much it will help people in other groups. This will, without a doubt, hurt the dual-eligibles, and hurt some of them very badly.

People with developmental disabilities who live in a group home in New Jersey are already required to give 75 percent of their monthly SSI check to DDD. So they have very little money available for the basic necessities. So that, if they then have to start with copays, it's going to be really devastating. Furthermore, it is not uncommon for people with developmental disabilities who are dual-eligibles to take between five and 10 medications on a daily basis, and some people take even more medication than that.

As you know, the deadline date for comments to CMS on the proposed Medicare rules was last October. The final regulations are not out yet. Along with my testimony, I've given you a copy of the comments that we submitted to CMS. Also attached to my comments is the clawback report that

several people have referred to. I'm not going to go into any details on it, but I just wanted to mention that it is attached to my testimony.

I wanted to talk a bit about US Pharmacopeia. That's the private company, under a contract with CMS, that released a draft of model guidelines on how prescription medications would be classified for purposes of the Medicare Part D benefit. We're deeply concerned about this, because the Medicare law states that prescription drug plans are required to cover only two prescription drugs in each medication class. Therefore, the grouping of medications into a class becomes extremely important. To illustrate this point, I will describe what the model guidelines did with the class of antidepressant medications. And Cathy referred to this a little bit, but it's so important that I want to go into it a bit myself.

Just to help you understand this -- within the class of antidepressant medications there are several major categories. There are the tricyclic antidepressants that Cathy referred to. An example would be Elavil. There are the SSRIs, the selective serotonin reuptake inhibitors. Zoloft is an example of that. There are also the heterocyclic antidepressants. Remeron is an example. The MAOIs; Nardil is an example. And then there are some other antidepressants that don't fit into any of the aforementioned categories, and Wellbutrin is an example of that.

The tricyclics, as Cathy mentioned, are the oldest of the antidepressants. They're viewed widely as having very problematic side effects, much more so than the newer antidepressants which are so widely used, which are the SSRIs. And some of the other widely known and name recognition -- the SSRIs -- are Prozac, Effexor, Paxil, Celexa, and Zoloft. The draft model guidelines lumped together all of the antidepressants into one medication class. And since the Medicare law requires the prescription drug plans to cover only

two medications in each class, it is very possible for the drug plans to be in compliance with the law while covering just two of the old tricyclic antidepressants and none of the newer and widely used SSRIs. This approach from the model guidelines has received harsh criticism from The Arc of New Jersey and other disability advocacy organizations. We submitted comments specifically on the model guidelines. We have no idea how our comments have been received.

However, even if our comments to CMS are taken into account and the drug plans are required to cover two medications in all of the aforementioned antidepressant categories, which is very unlikely, there would still be a major problem for many individuals with disabilities. Stated very simply, psychotropic medications and anticonvulsant medications, among others, are not interchangeable.

For example, a person who has a developmental disability and a seizure disorder may be very stable on one anticonvulsant regimen, but have uncontrollable seizures if that medication is removed. For the very vulnerable consumers with developmental disabilities who also have seizures, mental health disorders, and other serious medical conditions, their health will be jeopardized if their medications are switched simply to be in compliance with the formulary requirements. Furthermore -- and I think this is a comment that has not been made before this -- the MMA permits the drug plans to change their formularies, possibly with as little as 30 days notice. That was something that was in the draft regulations. Maybe they'll make it a little bit more than 30 days notice, but the fact is that during the course of the year, when people are really locked into their plan, the formulary can change, which creates a whole host of additional problems for vulnerable consumers with cognitive impairments, who

are going to have great difficulty understanding what this means if a notice comes in the mail telling them that their formulary is changing.

I'd like to give you just a very brief case example of Ryan. His name has been changed. This is a person who is 34 years old and a dual-eligible. He lives with his mother, who is a widow on a very limited income, and these are his diagnosis: Severe mental retardation, autism, grand mal seizures, allergies, and obsessive/compulsive disorder. The medications he is currently taking are Ativan, MiraLax, Neurontin, Tegretol, Zonegran, Zyprexa, and Zyrtec. I have other case examples which I don't need to go into, but I think you get the picture that we are talking about a very vulnerable group of people taking multiple medications.

It is noteworthy that the Medicare PDPs are not going to be responsible for paying for any adverse health outcomes, such as additional visits to the emergency room or hospitalizations that are likely to occur due to rigid formularies that prevent dual-eligibles from receiving nonformulary medications -- the same medications that they receive at no cost right now under our Medicaid system. And obviously, our folks are not going to be in any position to pay out of pocket for medications that are not on the formulary.

The Arc of New Jersey is extremely concerned that the grossly inadequate Medicare formulary process will be like a game of Russian Roulette with the health and well-being of many individuals with disabilities hanging in the balance.

Okay. So now what are the recommendations for how to try to deal with this? Obviously, the first recommendation is that intensive efforts need to be made to the Federal Government, to Congress, and to CMS regarding the significant harm that the Part D benefit will likely cause for New Jersey's dual-eligibles. Since the intention of Congress was to be helpful to Medicare

beneficiaries in passing the MMA, it is necessary that our members of Congress and CMS be informed that New Jersey's dual-eligibles will be much worse off under the Part D benefit than they were before. We should try to have the Part D benefit amended to change the aspects of the law that are harmful to the dual-eligibles.

For example, we've submitted in our comments that an open formulary for the dual-eligibles is essential. Again, we don't have any comments back from CMS, but an open formulary would be similar to what we have right now. I don't know how likely it is, but that's certainly something that we want to advocate for.

The other thing is that, given the time frame that is before us and the fact that there is so much right now that is unknown, we don't know who the PDPs will be. We don't know what the formularies are going to look like. There is a lot that is to be forthcoming, and there isn't going to be a lot of time from when that information is given to us until the November 15, 2005, start date for the enrollment process for the dual-eligibles. We have recommended, and we would appreciate anyone's help in furthering this cause, that there be a 12-month delay for the dual-eligibles in the time that they're expected to enroll in the Part D benefit. That would allow everyone the opportunity to find out what truly is going on and to work out a reasonable way to have this transition take place. And since our dual-eligibles under the current system are getting everything they need, the one-year delay would mean -- what we would propose is a delay in the clawback. Just push everything one year back so that we could continue with our system, which worked so well, for an extra year. It could go forward for the people for whom this will be helpful. I think that will be wonderful. Just take the dual-eligibles, give them that extra cushion of time so

that we can really figure out what the best way is to be sure that they will not be hurt.

We don't know for sure what's going to happen on the Federal level, but those recommendations, I think, would be helpful. Now, on the state level, we do need to determine what the most appropriate way is for New Jersey to fund the necessary wraparound coverage for the dual-eligibles. The PAAD program would seem to be a good mechanism for this funding. I realize that no one knows how much money will be saved at this point. It depends to a great extent on whether they're able to autoenroll. So, again, there is a lot that is not yet known. But that certainly could be a vehicle for funding the coverage that we need to help the dual-eligibles, both on the copays and for the medications that they need that are not in the formulary.

There's another comment that I don't think has come out until now. With regard to the types of plans that we expect to be available under the MMA, there are going to be things that are called, sort of, your standard plans. And the dual-eligibles, as I understand it, would be permitted to enroll in those with no deductible and no premium, just paying the copay. But my understanding is that those plans aren't going to provide very much. There are then going to be better, more comprehensive plans. If a dual-eligible chose to enroll in those plans, that person would have deductibles and they would have premiums, as well as the copay. The likelihood seems to be that those more comprehensive plans would have a better formulary. So in the final analysis, it probably would be far better for them to be in a plan with a better formulary. They can't afford a deductible and the premium. That would be a way that, if PAAD or some other entity could pay that for them and if they could be autoenrolled, it might be something that could be workable. But there's so much right not that's unknown.

We need a comprehensive plan for a seamless transition for the dual-eligibles into the Part D benefit. As you understand, this is going to be an extremely difficult and challenging process. Some dual-eligibles also have physical disabilities, cognitive impairments, language barriers, and/or communication difficulties. There will likely be significant difficulties in educating and enrolling such a large number of people into a new and complicated system. These challenges would be daunting even for people who had no disabilities and no cognitive limitations.

In conclusion, The Arc of New Jersey is working with a coalition of disability advocacy groups that are focusing specifically on the needs of the dual-eligibles. We are ready and willing to work with the State Legislature, the Department of Human Services, the Department of Health and Senior Services, and all other groups to develop a plan for a transition that is as successful as possible and, most importantly, which does not harm the dual-eligibles in the process.

Thank you.

ASSEMBLYMAN GUSCIORA: Thank you, Beverly.

Now, you gave us a packet and the recommendation to delay the onset. Is that in here somewhere?

MS. ROBERTS: To delay -- that was in the comments that The Arc of New Jersey submitted to CMS. I know it's lengthy comments, but--

ASSEMBLYMAN GUSCIORA: Okay. It's in the second half. Okay. Great.

MS. ROBERTS: Yes.

ASSEMBLYMAN GUSCIORA: Thank you very much.

Are there any questions from the members? (no response)

Well, again, thank you panel. It's certainly something that we're very sensitive to. I know you testified at our last hearing that this is something that we definitely-- If there are any savings, we would be fully recommending that we hold everyone harmless and that they not lose benefits. I think that's important for our citizens.

Thank you very much.

MS. CHIN: Thank you.

MS. ROBERTS: Thank you very much.

ASSEMBLYMAN GUSCIORA: Sue Gottesman.

SUE GOTTESMAN: It's Gottesman, a derivative of *God's man*, on how to pronounce it.

ASSEMBLYMAN GUSCIORA: Oh, I'm looking at a *U*.

And Alex DelPizzo.

Welcome.

MS. GOTTESMAN: Thank you. I want to thank the Chairs and the members of the Committees for your wonderful interest in the concerns related to these issues, and for your patience in staying so long. In the interest of time, I'm going to try to win the shortest testimony award, and I'm going to just quickly highlight what's in my written testimony.

I do want to say that I agree and endorse the statements of my colleagues who just left the table. Again, my name is Sue Gottesman. I'm with the New Jersey Council on Developmental Disabilities. Essentially, our concerns center around many -- the things that were raised all morning and afternoon, concerns about the affordability of needed prescriptions and the concerns about the availability of the right prescriptions. Affordability, as you've all heard-- We share concerns about the 25 percent share that many people will have to have, and the premiums; but also for the dual-eligibles, all

of whom our organization is concerned with. The copayments that can become -- that really can become unmanageable costs for people on many prescriptions, or for families with several children on many prescriptions. You can see how it adds up.

Seventy-one percent of dual-eligibles in the nation have annual incomes of less than \$10,000 a year. So when we're looking at premiums and copays, we need to look at it from that framework and what that can mean. The concern is that people will forego treatment when they can't afford copayments or if they perceive they can't afford copayments, and stop trying to get their medications. And this is a big concern, as the Kaiser Family Foundation has observed -- that where there is a desire to shift costs to consumers through copays and other limits, and caps, what you find is an increase in more expensive care, emergency rooms, hospitals, nursing homes. And they've done studies in terms of utilizations of prescriptions that where there are these types of cost containment, that fall harshly on consumers, you find people not filling their prescriptions -- which means people are being underserved, and ultimately the costs are higher.

Concerns about availability. I just wanted to quickly echo the concerns about the importance of particular drug regimens for individuals, especially where there is mental illness, developmental disabilities. These regimens are highly individualized and we're very concerned that the formularies are going to mean stops or disruptions in treatments for people that are very vulnerable.

One issue that hasn't been raised is that the FDA-- There is also a concern that people will not be able to get drugs that are not prescribed for FDA purpose. That when a company gets FDA approval, it's often for one diagnosis or one condition. And then as the drug is used, the medical community finds

that the drug is effective for other conditions, and it becomes widely used for other things that are not listed in FDA approval. And there's concern that the private Medicare plans will not allow those uses of the drugs. So there's other areas where we're concerned about availability.

And what we'd like-- Also, generic drugs are going to be pushed, and a lot of people can't use generic drugs. So these are concerns. As everyone said today, we're concerned that people continue to get the care that they need.

What we feel the State can do -- again, support and continue the supplemental programs and the wraparounds, to ensure that nobody has to take a step backward. To the extent that you can, work with Congress to push for modifications in the Federal law. Certainly we'd like to see the Federal Government negotiating for lower prices with prescription manufacturers. Also, perhaps, to explore whether it would be helpful to allow states to use some Medicaid money to supplement Medicare, which right now would have to be state-only funding.

Very important to have an appropriate exception process, so that people who are denied under the Medicare plans have a means to appeal and can get the medication that they need. And also, if we do go the way of a single preferred provider, it should have an open formulary.

Finally, the education piece is going to be critical to people who may not understand what they need to do or how to select a plan that has a formulary so they can continue their medical treatment.

Thank you again, and feel free to use us as a resource. Thank you.

ASSEMBLYMAN GUSCIORA: Thank you.

Alex.

ALEX DELPIZZO: Mr. Chairman, members of the Committee, thank you very much for the opportunity to speak before your Committees today. My name is Alex DelPizzo. I am currently a vice president for Winning Strategies Washington, which is a bipartisan government relations firm. Today I'm here on behalf of the Healthcare Institute of New Jersey.

It should be noted that prior to joining Winning Strategies in Washington, I served as Legislative Director for Congressman Mike Ferguson. In this capacity, I was directly responsible for working on the Medicare Modernization Act of 2003, specifically the areas where the Federal drug benefit overlapped with state pharmaceutical assistance drug programs -- in New Jersey's case, PAAD.

The purpose of my testimony is to clearly state what the Medicare Modernization Act of 2003 means to the State of New Jersey in terms of dollars. The figures that I am going to cite have been developed on a bipartisan basis by the Congressional Budget Office, the State of New Jersey, and the Congressional Committees of Jurisdiction.

New Jersey's State government could see the following savings under the Medicare law during the next 10 years: \$2.8 billion from PAAD. Because many of PAAD's enrollees will continue to receive their drug benefits under PAAD while their benefits will be paid by the Federal Medicare Insurance Plan, the State will save an estimated \$280 million annually during the next 10 years. It is imperative to understand that, under the new Medicare law, the State of New Jersey will never have to spend any State dollars on drug costs above \$3,600 per year on any individual senior that opts into the program. When you consider that seniors with catastrophic costs make up about 20 percent of the population, but yet 80 percent of the drug spending, the benefits

to New Jersey's PAAD program become instantly clear. And again, I want to reiterate, this is a savings that the Treasury in Trenton will not have to spend.

Seventy-three million dollars in-- The State of New Jersey has cited it's between 73, up to as much as 90 million that the State will see for the drug discount card. Before the formal Federal drug benefit begins in January in 2006, all seniors are eligible for a Federal drug discount card which will save every senior between 10 and 25 percent on prescription drugs. Low-income seniors will receive an additional \$600 credit annually, which can be used to purchase their medications. These funds have supplemented PAAD's spending, and will continue to do so until January of '06, saving the State government, again, an estimated, between 73 and 90 million. And as we've cited here today, it's already saved the State \$33 million.

Two hundred and twenty-two million dollars: New Jersey State government will receive a 28 percent tax-free subsidy to offset the costs of the prescription drug coverage it provides for all their retired State employees. So every teacher's union or whoever the State of New Jersey is providing retirees' drug coverage, the State receives a 28 percent dollar-for-dollar, tax-free subsidy.

Eight hundred and seventy-two million: Seniors who qualify for the Medicare and Medicaid -- and there's been -- many talked about dual-eligibles here today -- will continue to receive their drug benefits under PAAD. However, Washington will have to pay the cost, not Trenton. This provision will save the State an estimated \$872 million over the next 10 years.

It's very important to understand that when we talk about the dual-eligibles and how there's been a lot of discussion about how there could be increase in premiums and copays, this is an opportunity where the State clearly has the dollars. And now they just need to invest those dollars to continue care for those seniors that are most vulnerable. The thing about this provision is

this: Is that the State will have all the dollars to do so. The key is how the State chooses to wrap around the Federal benefit, which again is going to be up to the members of this Committee and others in the State Assembly.

I think Assemblyman Gregg hit it correctly -- is, we need to look at where those seniors need help and how the State can actually help those who could become vulnerable. Once the State has these dollars, which they will through the cost savings, they can choose to wrap around anyway they choose. But the bottom line is, the Federal Government is providing a savings for the State to do so.

New Jersey has also already received \$22.6 million in Federal funding for transition assistance, before the new Medicare benefit formally begins in 2006, to ensure full coordination and education between Medicare insurance plans and PAAD. Finally, there was also a one-time \$80 million payment which increased the Federal Medicaid reimbursement rates in New Jersey from 12 to 16 percent for one year. State government spending will be reduced by \$80 million. These figures represent a tremendous savings to the State of New Jersey's Treasury at a time of record deficits. The State of New Jersey is expected to spend over 600 million on PAAD in the upcoming year. The Federal Medicare law will offset most of that spending. In fact, for low-income seniors -- those with incomes below 135 percent of the Federal poverty level, or about 12,900 for individuals, 16,600 for couples -- the new Medicare benefit will operate just like PAAD -- no premiums, no deductibles, and low copayments, \$2 for generics, \$5 for brand-name drugs.

The State of New Jersey will not be responsible for any prescription drug spending for these individuals, and the program is even more generous than PAAD in the respect that it's \$2 for a generic, whereas in PAAD it's \$5.

The story of how little New Jersey gets back from the Federal government is often told in Trenton and throughout the state. While generally this is very true -- and the last figure I saw, I believe, was 57 cents on the dollar that we get back from the Federal Government -- it is not the case with the Medicare Modernization Act. Because we made a commitment to our seniors with the creation of PAAD, New Jersey stands to gain significantly under the MMA. While I understand that, like most issues in Washington, this has a potential to become a very partisan issue, the dollars that the State stands to gain from this law cannot be mistaken. The State of New Jersey can receive almost \$4 billion over the next 10 years. I'm not aware of any other Federal program where the State benefits this much.

And I'd also like to go back on one bit of testimony, that was mentioned earlier, about the State out of pocket. And somebody actually referenced Senator Grassley, and that they had received -- and Senator Grassley has gone to receive a legal opinion from CMS. The amendment in question actually talks about how state spending counts toward the Federal catastrophic. So, therefore, any money that PAAD spends, or any other state SPAP, goes toward the Federal out-of-pocket spending so that the state, on the back end, is off the hook on the catastrophic coverage. This amendment was actually written by Congressman Ferguson and inserted into the bill with New Jersey in mind. So I know that our congressional delegation -- this is overwhelming. The amendment was actually sponsored by Congressman Palone as well, which, if you guys know anything about Congressman Palone and Congressman Ferguson, they agree on little. But this is actually one case where the delegation worked on a bipartisan basis to benefit PAAD and the State of New Jersey, so they see significant savings.

So there was mentioned that Senator Grassley has received one legal opinion, the State of New Jersey has received two. There will be some debate on this issue. But I can tell you, the clear intention of this provision is that these dollars go toward the Federal catastrophic.

So thank you very much, and I'm available for any questions.

ASSEMBLYMAN GUSCIORA: Thank you, Alex. And I know, certainly, Congressman Ferguson has our best intentions in mind.

I'm just struck by how the Department of Health has testified that we have no idea how much we're going to benefit, and then you say we're going to benefit \$2.8 billion. How could that scenario be so far off?

MR. DELPIZZO: Well, because-- If we-- Well, first, if they couldn't--

ASSEMBLYMAN GUSCIORA: Are they going to guarantee us that?

MR. DELPIZZO: They couldn't guarantee-- Well, the Department, obviously, couldn't guarantee us, because they're not sure how the wraparound is going to work. But working with, again, the Governor's Office and the Committees of Jurisdiction, who wrote this legislation with CBO, if the State does a seamless wraparound, as we intend that they're going to do-- So the reality is this, the State has two choices: The State can look at the situation and say, "Okay. We want to make this as seamless for our constituents as possible and make this work," or they can walk away from the \$4 billion. Now, given the deficits in Trenton, I don't think that's going to happen. I think, obviously, it could. But if they wrap around the way that we imagine they will, and can pretty much -- not guarantee, because obviously you're going to have a lot of say in that. But if they wrap around the way they should, to make the benefit seamless, you're going to see, as a result of the beneficiaries -- and again,

this does not take into effect if there is an autoenrollment, which has -- we've seen already, on two occasions, CMS has agreed to this. These are the cost savings you will see.

Now again, this could be reduced depending upon how the enrollment factors go. But given the fact that the State more than likely is going to take this Federal dollars -- will take these dollars, this is the savings that you can-- Again, it's an estimated figure. But these are estimates that we'll work through with CBO, the State of New Jersey, the Governor's Office, and the Committees of Jurisdiction; and how it would apply to the State PAAD program.

ASSEMBLYMAN GUSCIORA: Is that blueprint that you're talking about, is that available? Does our State know about that?

MR. DELPIZZO: The State was actually involved in creating the blueprint. This was done with CBO.

ASSEMBLYMAN GUSCIORA: Is that available for our scrutiny?

MR. DELPIZZO: I can certainly try and get that to you.

ASSEMBLYMAN GUSCIORA: That would be great.

And also, there was testimony, certainly before, about the providers of the developmentally disabled; and also the dual-eligibles, who are now our lowest income, are actually -- or at least at -- one-fourth of the beneficiaries are going to have to now put out a substantial outlay. Is that correct?

MR. DELPIZZO: Well, I wouldn't call \$1 and \$3 substantial. I understand it is substantial to this population.

ASSEMBLYMAN GUSCIORA: Well, if you're making \$9,000 and you're--

MR. DELPIZZO: And this is precisely where the State benefit could wrap around. And \$1 and \$3, to the State of New Jersey, when you're

considering all the money they're saving on the back end-- Because while they might be -- if they choose to wrap around, which we imagine they will, the State would be responsible for that \$1 and that \$3. However, they're not responsible for the rest of the drug costs now. The Federal Government is. So while there is an outlay from the State, it's significant -- the savings.

ASSEMBLYMAN GUSCIORA: But that was accurate that at least a fourth is going to have to pay more.

MR. DELPIZZO: That the State could have to pay \$1.

ASSEMBLYMAN GUSCIORA: Which is substantial, if you're below the poverty line. Even \$250 is a lot of money to some people, as our former Governor said.

MR. DELPIZZO: Right.

ASSEMBLYMAN GUSCIORA: It is.

MR. DELPIZZO: But, no, no. I'm not--

ASSEMBLYMAN GUSCIORA: It is a big blow to the lowest of poverty.

MR. DELPIZZO: Absolutely. But I think that's a two-part question. Because while there is an outlay by the State, you also have to understand the savings the State maintains because of that as well. It's not just an outlay with no savings on the back end. It might be an outlay for the beneficiary, which they didn't previously have. Because under New Jersey, the Medicaid there is no copay. However, now there's no back end for the State to pay either. The Federal Government takes up that cost.

ASSEMBLYMAN GUSCIORA: Now, is there a way that in your expertise, since you worked on this bill, that we can correct what the mental health people brought up -- that it would interfere with the regimen that many people would have to take if they're on a set prescription drug plan?

MR. DELPIZZO: Right. Could you clarify your question?

ASSEMBLYMAN GUSCIORA: How can we correct that -- with the testimony that the mental health people just gave us?

MR. DELPIZZO: Well, I think with what you're looking at you're going to have choice. So obviously you're going to choose a program that has the drugs that are available that you would want.

ASSEMBLYMAN GUSCIORA: But if you don't have that?

MR. DELPIZZO: Well, I think everybody will have choice. That's the first thing. The second thing is, any drug that's deemed medically necessary by your doctor, Medicare cannot deny you. That is in the statute. You will get that under law. So anything that is medically necessary, as deemed by your doctor, you will receive. That is specifically written into the law for that purpose.

ASSEMBLYMAN GUSCIORA: With the benefit though?

MR. DELPIZZO: Correct. Absolutely. Under the benefit. It's in the statute.

ASSEMBLYWOMAN POU: I'm sorry. Can we just take that one step further.

MR. DELPIZZO: Sure.

ASSEMBLYWOMAN POU: I believe that before I stepped out of the room there was some testimony that the medication was based upon certain groupings, and some of those groupings would not necessarily have the type of medication eligible for, under the prescription -- eligible for the program that you were referring to. How do you then ensure that that individual is receiving the medication that he or she -- is needed?

MR. DELPIZZO: Well, again, if the medication is deemed medically necessary, the law by statute must provide that. Obviously, a doctor has to--

ASSEMBLYWOMAN POU: Even though that medication may be different and cause a different effect on that particular patient?

MR. DELPIZZO: I don't quite understand your question.

ASSEMBLYWOMAN POU: The grouping of the medication-- Because the way the medications are grouped for eligibility, it was my understanding that certain medications were not eligible under this particular--

MR. DELPIZZO: Well, I think we need to understand that the benefit doesn't come out until 2006. So I don't think there's been any medication grouped, at least not to my knowledge. There might have been proposed--

MS. GOTTESMAN: The formularies are being developed now.

MR. DELPIZZO: There's -- no formularies has ever been put forth, as far as I know. So I don't think that's an accurate statement.

ASSEMBLYWOMAN POU: So, okay. All right. Well, then it could be. But we don't know. And obviously, since you've just said it hasn't come out, it could possibly be the case. And you, yourself don't know, or the mental health folks--

MR. DELPIZZO: I don't think anybody knows, because they're--

ASSEMBLYWOMAN POU: --would not know as well.

MR. DELPIZZO: Correct.

ASSEMBLYWOMAN POU: So there's still a lot of uncertainty here, is what you're saying.

MR. DELPIZZO: Absolutely. And then the other part of that is, this is where the State can wrap in and pay for that, because they'll have the

resources that the Federal Government gave them. That's the other part of the equation.

ASSEMBLYWOMAN POU: Well, sure. Yes, absolutely. We can do that. It will certainly go into the cost savings, but yes.

MS. GOTTESMAN: I'm very sorry. I think it would be unfair to oversimplify the ease -- the supposed ease with which a person could get all their medications. There may be choices between plans. It's going to be quite a trick to find a plan that has all the specific drugs listed in your formulary, if there are closed formularies. And I think part of the concern is that what's been proposed for the private Medicare plans is really the exception, not the norm. Ninety-eight percent of private prescription plans have open formularies, as does the Medicaid plan. So this is something that is new, and has many major national disability advocacy organizations quite concerned that their constituents are going to be without the drugs that they need. The same thing with the cost. It's not a dollar. If you need brand name, five to ten drugs, and you make less than 10,000 a year, it's not insignificant and it can't be brushed aside.

Thank you.

ASSEMBLYMAN GUSCIORA: Assemblywoman.

ASSEMBLYWOMAN VOSS: I have a lot of concerns just listening to the testimony. It seems as if we're making our most vulnerable population -- our senior citizens and our people with disabilities -- having to make choices in a very short period of time. And who is going to help them make these choices? I mean, they are the most vulnerable. I'm also very concerned about the fact that we're sitting here listening to testimony, but the formulas have not been established.

Now, being somewhat familiar with mental health and disabilities, if some of these people, as we have heard, take numerous medications and

they're going to set up some kind of a formula -- and certainly with psychiatric drugs -- they're always coming up with something new. And if you put these formulas into effect, you're really doing a disservice to the population that needs to be in the forefront of these new medications. And this disturbs me very, very much. Because I don't like the one-size-fits-all kind of formulas, and I also don't like people with severe challenges having to make choices which they may be ill-equipped to make. And this is something that I find extremely disturbing, from all of the testimony that we've heard.

ASSEMBLYMAN GUSCIORA: Beverly, you had something to add?

MS. ROBERTS: Yes. I just wanted to add an additional comment. And I'd be happy to give you the draft of the model guidelines that US Pharmacopeia had sent out. This was back in the summer. So the comment period is long gone. But I'm just a bit confused about some of the information you just heard, because everything that we had seen-- And it's true, it was a draft. But when US Pharmacopeia came out with their draft model guidelines -- and it was an enormous task -- they came out with looking at every class. When I gave my testimony, I talked about antidepressants. But anticonvulsants -- every category of medication was looked at very clearly. And then they talked about how the groupings were going to be set up. So when I gave my example of antidepressants and all the different categories of antidepressants, they, in their model guidelines, put that in as one chunk. Every antidepressant, that's been FDA approved, in the model draft guidelines is one chunk. And my reading of the information was that, out of that one chunk, each PDP would be able to select two FDA-approved antidepressants, and that would meet the criteria. And I know comments have gone in saying that that should be changed. But that's the way the model guidelines were put out.

The other thing that I'd just like to say is, when you talk about somebody who is taking many medications -- six, eight, 10 medications -- on a daily basis, it becomes that much more difficult to look at a PDP and expect or hope that those 10 medications that that person needs will be available in one PDP. If a person is taking only one medication, let's say, and they search all the PDPs, it's maybe pretty likely they could find what they need, hopefully. But the more medications you take and the more complex, the more difficult with the closed formulary it may be. That's my comment.

ASSEMBLYMAN GUSCIORA: Thank you.

MR. DELPIZZO: Can I follow up on that for a moment?

ASSEMBLYMAN GUSCIORA: Yes.

MR. DELPIZZO: I think that's an excellent point. I think this speaks to two things. Is that the State here really does have the dollars, providing that the State chooses to opt into the program. The State has the dollars here to help our population. And also, I think this further proves the need for the continued work, for instance, as we did on the drug discount card with the opt in -- with our congressional delegation in D.C., to work with CMS to alleviate any concerns that the members might have. But I think that the real key here is that the resources are there.

ASSEMBLYMAN GUSCIORA: And you'll work on that for us?
(laughter)

MR. DELPIZZO: Absolutely.

ASSEMBLYMAN GUSCIORA: Thank you.

M A R I E V E R N A: Hi. My name is Marie Verna. I'm the Director of Consumer Advocacy for the Mental Health Association in New Jersey -- Cathy Chin's colleague. I also am the liaison to our national organization, the National Mental Health Association. And I just want to reiterate, Alex, that the

National Mental Health Association also responded to the request for recommendations to the guidelines. And the issue about the formularies is our primary issue. And of course, we won't know until we see those final regulations, but by no means do we think it's a guarantee that the formulary is not going to be a problem. We're anticipating a problem. And in fact, from the National Mental Health Association's point of view, and New Jersey, that's our primary issue right now -- is how to get New Jersey's congressional delegation to effect the regulations right now. We know we can't amend the bill. We know we lost that opportunity. But right now we have to make sure that our Republican delegation is batting for mental health consumers in New Jersey.

Our Monmouth affiliate visits Mike regularly, talks with Mike regularly. But that is our primary concern. By no means do we think that the issue of access to the full range of medications is a done deal.

MS. ROBERTS: We have all requested an open formulary, I think, in our comments to CMS -- that an open formulary for the dual-eligibles is something that we very much want to see. And to the extent that anyone has any pull with CMS, we would be very appreciative if that were their final decision.

ASSEMBLYMAN GUSCIORA: Well, Alex said he's going to go back to Washington and correct that. (laughter)

MR. DELPIZZO: I'm going to work on that for you. (laughter)

MS. ROBERTS: Okay.

ASSEMBLYWOMAN POU: Assemblywoman Greenstein.

ASSEMBLYWOMAN GREENSTEIN: Now, I want to support what I'm hearing these folks say here today, as an attorney for the mentally ill for many years with the Community Health Law Project. I've worked with this population, as most of you know. And you're absolutely right. These folks

take many different drugs. And I think the whole concept of the formulary is based on the idea of cost cutting and of somehow trying to reduce the number of medications that people take. I think that's the philosophy behind it, perhaps one that isn't always admitted. But I think it's an extremely dangerous one, and most particularly with the people who suffer from mental illness and other disabilities, because they do need this very complex balance of medications.

I think to even try to take the approach that perhaps there should be a cutback in that, perhaps change a couple here and there, go for less expensive drugs, generics even, could be very dangerous in these situations. And so I think it's very important, perhaps, to single this group out and to make certain that we do everything possible to make sure that they're not subject to these rules. And I think that could be one of the things that we try to emphasize as well. Maybe that's one of the approaches this Committee can take. But I certainly do support what you're saying.

ASSEMBLYWOMAN POU: Thank you, Assemblywoman.

Assemblyman Guy Gregg.

Sorry. I was looking at you, but I-- (laughter)

ASSEMBLYMAN GUSCIORA: If I was the Chair, I would have picked Tony first.

ASSEMBLYWOMAN POU: I was looking at you, Assemblyman, but I promised Assemblyman Gregg that I would--

ASSEMBLYMAN GREGG: It just appears to me I must be on your mind all the time. (laughter) And that's comforting to me. (laughter)

Thank you.

ASSEMBLYMAN GUSCIORA: Not to Nellie, though.

ASSEMBLYMAN GREGG: It really just took the wind out of my questions. (laughter)

ASSEMBLYMAN CHIAPPONE: Assemblyman, you need a moustache.

ASSEMBLYWOMAN POU: It was perfectly done for that purpose.

ASSEMBLYMAN GREGG: Perhaps I need one of those antidepressants now.

Alex, I just want to go over one second of your testimony--

MR. DELPIZZO: Sure.

ASSEMBLYMAN GREGG: --because I know everybody wants to go home. It's been a very informative day. All of your testimony has been excellent. You've educated us. Obviously, there are some issues that are special to New Jersey, and I'm sure that other states are debating some of these same things today, having their own special issues as they are moving forward with this huge new opportunity for the healthcare benefits in our country.

You said, I thought, through the Chair, that in the statute, the bill, that it clearly states and was amended that any medication required by a physician will have to be given to that patient.

MR. DELPIZZO: Correct.

ASSEMBLYMAN GREGG: And that is in language in the bill.

MR. DELPIZZO: That's in the statute. Any drug that's deemed medically necessary by the physician. Again, it has to be by a licensed doctor.

ASSEMBLYMAN GREGG: So even as laborious as it may be, if they made such a horrible set of compartments of drugs and programs--

MR. DELPIZZO: Correct.

ASSEMBLYMAN GREGG: --and one individual was taking 10 drugs, each one of those 10 drugs was prescribed by a prescription, by a doctor,

and each one was in a different one of these compartments we're talking about -- these alleged new potential compartments -- that the pharmacy would fulfill that commitment.

MR. DELPIZZO: As long as it deemed medically necessary, that is correct.

ASSEMBLYMAN GREGG: So--

ASSEMBLYMAN GUSCIORA: And reimbursable under the plan?

MR. DELPIZZO: And reimbursable. No, under the statute. It must fall under -- absolutely.

ASSEMBLYMAN GREGG: Feel free to interrupt. Yes. I mean, really.

Yes. And reimbursable.

MR. DELPIZZO: And reimbursable.

ASSEMBLYMAN GREGG: It wasn't part of my question, but it's the Chairman's question.

MR. DELPIZZO: Treated as any other drug under the statute.

ASSEMBLYMAN GREGG: Exactly. And while I certainly understand the points of view of the folks that are here -- that their roll is to anticipate potential problems, and that's good; and we need to anticipate other problems, which is also good -- but it does appear that there was some good, thoughtful process done in the statute itself to ensure that there was protection, regardless of what would occur in a regulatory process.

MR. DELPIZZO: And frankly, this was done at the request of members from New York, New Jersey, and Pennsylvania. Because obviously, these three states are in a much different position -- unique because of the very generous prescription drug programs that are in these three states. While there were -- I believe, at the time, there were 34 different states that offered various

drug programs at the time of the Medicare law. The three driving this was, again, the congressional delegations of New York, New Jersey, and Pennsylvania, due to the fact that their programs were obviously far more generous than any of those others. So they had an obligation to fulfill their state's, I would like to say, commitment -- that we've been fulfilling to our seniors for over 25 years, in this state.

I guess the point I'm trying to make is that in good faith your delegation, as well as New York and Pennsylvania, are setting out to do just this. Because the last thing any member of Congress wants is some senior calling them up and saying, "I can't get my drugs, and it's all your fault." The point I'm trying to make is that (a) there are statutes of things put in place at the request of these delegations, there are backstops. And, there's also resources from the Federal Government to provide the State the flexibility it needs to pay for these things.

ASSEMBLYMAN GREGG: And just-- I don't want to continue the debate about how much money we're going to save, just from an example standpoint. We were talking about the copay, which certainly I think is incumbent on us to address as a State. It will be one of those things we have to deal with. But utilizing-- Not knowing what the savings will be, it would be obvious to me that-- Let us assume that the individual is going in for this specific drug; they are now not eligible for a no-copay situation. They have a \$1 copay. The drug they're buying is probably \$10, \$15, \$25, \$75 worth of drug.

MR. DELPIZZO: I'm not an expert on that, but it is significant.

ASSEMBLYMAN GREGG: Let's just say it's \$25, for arguments sake. You don't get too many prescriptions under \$25. So you've got a \$25 prescription that somehow we have to find a \$1 for, whether it's the individual,

which we don't want. The State may have to pick up that \$1. The Federal Government has now picked up 24. Would that be correct?

MR. DELPIZZO: That is correct.

ASSEMBLYMAN GREGG: So we know without knowing, without seeing it in writing, that that kind of a program that we're moving into is going to save us everything other than the \$1. And that's the term you used, back end.

MR. DELPIZZO: That's the back end benefit that the State is going to see.

ASSEMBLYMAN GREGG: I just wanted to make it more personable, to say that this is what really is going to happen. The State will end up with a potential liability of a copay, while the total other cost of the drug, that we used to assume in the PAAD program, will now have been picked up by the Federal Government.

MR. DELPIZZO: Exactly.

If I may indulge the Committee, could I just give an example, quickly?

ASSEMBLYMAN GREGG: I'm not the Chair.

MR. DELPIZZO: And I'll make it very brief.

ASSEMBLYWOMAN POU: Go right ahead. Go ahead. Go right ahead.

MR. DELPIZZO: Madam Chair, say my grandmother in South Jersey is under the PAAD program. Say her drug spending again -- let's say she pays her \$5 to PAAD. Let's just say the cost of her drugs were \$200 a month. She'll go under the Federal benefit with the wraparound, okay. She will pay, for her -- \$5, continue to pay it. Rather than the State of New Jersey paying the 190, the Federal Government is going to pay it. That's the difference. That's the real benefit for the State. The expenditure is still there on the front end. But

the back end is where the Federal Government and the State are going to have to coordinate. And the wraparound -- that's going to be up to this Committee and others within the Assembly. But that back end is really where the benefit's going to be for the State.

ASSEMBLYWOMAN POU: Mike, I would--

MR. DELPIZZO: It's no longer paying-- Instead of the State paying that \$190, it's the Federal Government.

ASSEMBLYWOMAN POU: Mike, I was just going to mention it depends on the wraparound though. It depends on exactly how that wraparound program is, indeed, put together--

MR. DELPIZZO: And that's up to you.

ASSEMBLYWOMAN POU: --and the dollar amount will dictate how each of those programs will be put in place--

MR. DELPIZZO: Absolutely.

ASSEMBLYWOMAN POU: --to be able to yield the kind of benefits that you've just used as part of your example.

MR. DELPIZZO: But the reality is, the State's paying that now.

ASSEMBLYMAN GUSCIORA: I also want to emphasize that our PAAD and Senior Gold program, the testimony was \$600 million a year. Even under your best scenario, the Federal Government is only going to give us 280 million of that. So it's not going to be--

MR. DELPIZZO: For that portion. Just for that portion. Remember that there's a multi--

ASSEMBLYMAN GUSCIORA: Well, you just said that of the \$95 on this one prescription, the Federal Government will be paying for it. That's not really true.

MR. DELPIZZO: Well, you see-- It depends on her income eligibility. It is true.

ASSEMBLYMAN GUSCIORA: The bottom line is, we spend 600 million for our drug program. We'll probably continue to pay the bulk of it. And while, yes, it's true the Federal Government will give us money, that's yet to be determined. That's what we're here to make sure--

MR. DELPIZZO: Right.

ASSEMBLYMAN GUSCIORA: --that mechanism gets in the place that's seamless, that we can optimize our Federal dollars.

MR. DELPIZZO: Correct. Correct.

ASSEMBLYMAN GUSCIORA: But we'll still -- the State of New Jersey will still be shelling out money for a prescription drug program.

MR. DELPIZZO: The State of New Jersey will. And there are, again, cost savings that we already know we're going to get.

ASSEMBLYWOMAN POU: I'd like to-- I promised Assemblyman Chiappone that I would call you next, and I absolutely want to keep that promise.

I just want to mention, before I call upon you, Assemblyman, I'd like to really try to complete our hearing. It's now -- I'm assuming that's correct -- it's now twenty to two. I'd like to really try to wrap it up, certainly before that, but no later than 2:00. The clock is going to tick, and we're going to end our hearing. It's been a very long day. It's been very informative.

I want to take this opportunity to really express my sincere appreciation to all of you who have provided us with a wealth of information. We've taken in a lot. There's been a lot of very good clarifications. There's been some very good questions, and some excellent responses and information given to us in writing. So our job is certainly in front of us. Our job is to go

back and take a look at all of the information that's been provided to us. We want to be very diligent in making sure that we're looking carefully at what the next step for the Federal Government will be, in terms of the regulations -- how we're going to be affected, and what are some of the best programs that will help to ensure that our citizens, in the State of New Jersey, are protected and are provided with the kind of medical pharmaceutical needs, and their medication, that are absolutely important and necessary.

With that, I would like to call upon Assemblyman Chiappone, and followed by Assemblywoman Greenstein. And after her questions, I'm going to close our questions for any closing remarks.

Thank you very much.

Assemblyman.

ASSEMBLYMAN CHIAPPONE: Thank you.

Thank you, Mr. DelPizzo.

MR. DELPIZZO: Yes.

ASSEMBLYMAN CHIAPPONE: And I, too, following Chairman Gusciora, would like to see the blueprint--

MR. DELPIZZO: Sure.

ASSEMBLYMAN CHIAPPONE: --to those estimates of 2.3 billion over 10 years, and 280 million per year. My question is, assuming -- and I imagine that one of the things the State will do, will attempt to compensate those who will be left out of this program. And it's been established through previous testimony that one out of four beneficiaries will see a reduction in coverage and an increase in payments. I would like to ask you, in this analysis that you provided, if the State were to compensate for those who will now have to incur increased payments, would you have any idea of what the yearly cost

to the State would be if we were to account for those dual-beneficiaries or those who will see an increased cost?

MR. DELPIZZO: I think we need to-- It wasn't clear to me that we've established that one in four are going to see an increase. My understanding is, when we're talking strictly with the dual-eligibles here, this is just a dual-eligible portion. And we're talking about the State, that the portion that the State of New Jersey pays -- is that you could see now a beneficiary who currently, under Medicaid, as in the State of New Jersey, currently does not pay, again, a copay. The new copay for the Federal benefit, if you are under 100 percent of Federal poverty, is \$1 and \$3. So what I would need then, would just be to get that number of beneficiaries in the State of New Jersey -- I'm sure somebody could probably scare that number up through all the testimony -- and simply multiply that times \$1, times the number. Again, we have to factor in the number of prescriptions that they do receive. So I'm sure that that -- roughly, I can't imagine it would be any more than half a million. I mean, I'm grasping at straws. I mean, it would not be-- I don't think for the -- talking about the State of New Jersey, it would not be a significant outlay.

ASSEMBLYMAN CHIAPPONE: We're not just talking about copayments. We're talking about those who would incur out-of-pocket expenses to the average of \$500.

MR. DELPIZZO: But the out of pocket would be the copay, because the Federal Government would take care of the rest of that. The out of pocket is the actual copay, because the Medicare law then -- under Medicare, the new Medicare benefit -- if you're under that level of poverty, that's all you pay is the \$1. There's no premium, no deductible; there's a \$1 copay. And that is specifically -- correct me -- as the panel suggested. The reason that's in there is because, on a massive scale -- this is not, again, take away New Jersey and the

PAAD program -- the Federal Government put that \$1 copay in there. It's more symbolic than anything else. Because as a scoring mechanism with CBO, it is, as this panel has correctly stated, proven that when you provide an actual outlay, the cost of usage would go down. And that's why they put the \$1 in there, as more or less just something to keep the CBO cost of the bill lower.

ASSEMBLYMAN CHIAPPONE: So is it your assertion that, according to the Kaiser report, that the 7.9 million people who will have to pay an average of \$500 out-of-pocket expenses -- that the Federal Government will then pick up those expenses?

MR. DELPIZZO: I would not even-- I'm disassociating myself with the Kaiser report. And I would just point out that that was a national figure, not a state figure.

ASSEMBLYMAN CHIAPPONE: Okay. Thank you.

ASSEMBLYWOMAN POU: Assemblywoman.

ASSEMBLYWOMAN GREENSTEIN: I just have a very quick question, for any of you I suppose.

We talked before about these formularies. And actually, the gentleman -- Mr. DelPizzo--

MR. DELPIZZO: DelPizzo, correct. Thank you.

ASSEMBLYWOMAN GREENSTEIN: We heard a little bit earlier about -- let me get my notes here -- that pretty much whatever a doctor recommends is okay. But if the plan has a formulary, wouldn't it have to be selected from that list?

MR. DELPIZZO: I'd like to clarify. It would have to be deemed medically necessary.

ASSEMBLYWOMAN GREENSTEIN: So let's say a doctor does that, but the particular program has a certain list of approved drugs.

MR. DELPIZZO: Well, no, because there could be certain drugs-- And I think, is correctly pointed again by this panel, is that-- For instance, in the mental health field, there's certain drugs that people -- the side effects are generally better for certain patients, depending upon their physical makeup, chemical makeup, etc., etc.

ASSEMBLYWOMAN GREENSTEIN: Right.

MR. DELPIZZO: And I think that goes into the point that it's deemed medically necessary. You would have to, again, go to your physician. You could not-- The whole point is that one of those drugs on that list wouldn't work for you because of your side effects. So therefore, it would be medically necessary for you to get -- instead of taking the Merck drug, you would take the Pfizer drug, or however you want to do it.

ASSEMBLYWOMAN GREENSTEIN: So even though a particular plan has a formulary--

MR. DELPIZZO: Correct.

ASSEMBLYWOMAN GREENSTEIN: --if your doctor feels you need 20 other drugs that are not on that list--

MR. DELPIZZO: You would get that.

ASSEMBLYWOMAN GREENSTEIN: You can get those.

MR. DELPIZZO: That's specifically to your point, which is -- that's why the provision was put in there. Because what if you had -- your Merck drug doesn't do what the Pfizer drug does. So, but yet, your Merck drug is the only one that is on the formulary. You would get the other drug, because that's what's medically necessary for you.

ASSEMBLYWOMAN GREENSTEIN: Now, let me ask you this, because I've also seen this problem in doing things over the years. If a doctor states that it's medically necessary, is somebody going to second guess his or her

judgment? Because that often happens in these situations, that there's some person, often a nonphysician, who will say, "Well, we're sorry. If you think it's medically necessary, we don't."

MR. DELPIZZO: There will be a Medicare board which will, again, have to certify that. That's absolutely correct.

ASSEMBLYWOMAN GREENSTEIN: Well, that's going to cause problems.

ASSEMBLYWOMAN VOSS: That's going to cause lawsuits. That's ridiculous.

ASSEMBLYWOMAN GREENSTEIN: That's going to cause a lot of problems. If it's medically necessary and the doctor says it, that should be the end of it. If it has to go through these boards, it's going to be a mess.

ASSEMBLYWOMAN VOSS: Absolutely.

MR. DELPIZZO: Well, again, let me just clarify that. And I think this is a great place where, again, you working with your delegation can insert your will. Because I don't think anybody set a criteria for what that board looks like, whether it's just CMS administrator, Dr. McClellan, saying, "Okay," or whether there's a clearinghouse where certain doctors are -- you're certified, and then anything you say goes. That hasn't been established. And that's something where I think, again, this Committee can be productive in working with CMS, and the delegation, and the Governor's Office to say, "Maybe these are some of the steps we need to take to make sure this doesn't happen." But I think your point is absolutely correct.

ASSEMBLYWOMAN GREENSTEIN: Now, I think it definitely is something we should work on.

Thank you.

ASSEMBLYWOMAN VOSS: Absolutely.

MS. ROBERTS: Can I respond to your question as well?

ASSEMBLYWOMAN POU: I'm going to-- I really want to close our meeting. I'm going to ask you to please make it very quick. I'm going to ask that if your comment, because I saw the other hands going up, if you can really-- I'm going to just--

MS. GOTTESMAN: I'll defer to Beverly.

ASSEMBLYWOMAN POU: Okay, thank you so very much, Sue. If you can make your closing comments.

And then I'm going to ask Chairman Gusciora for remarks, and we're going to close our meeting.

Please, Beverly.

MS. ROBERTS: I think, perhaps, all of us would appreciate seeing that part of the statute that Alex is saying definitively says that you can have whatever you need, because I don't recall that in what I read. I do recall an appeals process, which I viewed as extremely cumbersome, especially when we're talking about the level of disability, of who the dual-eligibles are -- people with mental illness, people with developmental disabilities, etc. So an appeals process, to me, which is extremely cumbersome, is not the same thing as being told, "Oh, it's medically necessary, you can have it."

The other thing is, when you have a formulary process and all the different PDPs, the physicians are not going to know what is or isn't on all of these different formularies. So the physician writes for whatever the person needs. And one of our many fears is, a person goes to the pharmacy or to the PDP, whoever is dispensing, and they're told, "Oh, well, you can't have that. That's not on the formulary." So right there you have a disconnect where, unless there's this wraparound which we're hoping would take place-- But if that didn't exist, a person goes, "You can't have that." So depending on their

level of cognitive disability, their level of mental illness, they may think, "I can't have medication at all," and just not take it. They may go back to the doctor and try to complain. You don't know what's going to fall through the cracks during all of this. And the ability to then determine that you have to file an appeal, what you have to do, and actually go ahead and do it -- and then who knows what the outcome is going to be?

As I recall, there was a request that even emergency medication should be provided -- like if you go to the pharmacy, you present with your prescription, and it's not on the formulary. I think we were begging to say, at least while we figure out what's going on, give them an emergency supply of the nonformulary medication, because the doctors aren't going to know what's what. So I just see so many different places -- and I know time is short -- but I see, for very vulnerable people, so many different places in which a rigid formulary is going to create huge, huge problems.

ASSEMBLYWOMAN POU: Thank you, Beverly. Thank you.

Thank you to all the members of the panel. I really appreciate your information and your testimony.

MR. DELPIZZO: Thank you.

MS. GOTTESMAN: Thank you.

MS. ROBERTS: Thank you.

ASSEMBLYWOMAN POU: Assemblyman Gusciora.

ASSEMBLYMAN GUSCIORA: Thank you, Madam Chair. I think, no doubt, that this has been a very informative and helpful hearing, and I do want to thank all the members who stuck it out today, because I think we still have our work ahead of us. I am an optimist. I'm not as optimistic as Assemblyman Gregg, but just, in general, I think that at the end of the day this has a potential to bring more Federal funding into the State. Our object, I think,

in the months and weeks ahead, is to optimize that and make sure that we do get the most amount of dollars.

At the same time, I don't think we can forget that the potential pitfalls in this-- We talked about a fourth -- it actually could be more, because it's a national average, and we, of course, have a disproportionate amount of urban poor. And, in fact, 80,000 of our 220 recipients of PAAD are dual-eligibles. So there's a potential that a little less than half of our recipients are going to have that pitfall where we'll have to pay that copay. And I don't make light of a \$1 copay. Because first of all, it could be up to \$5. And the other thing is that we all know that people take multiple prescriptions.

So, hopefully, we'll be able to reap any benefit we get from the Federal program, wrap it around so that people are held harmless. But I look forward to working with all my colleagues, and I think we've been better legislators for sticking it out today.

Thanks. (applause)

ASSEMBLYWOMAN POU: Thank you very much.

Let me wish everyone a very happy holiday -- happy Thanksgiving to you and your family. To the members that are here, thank you so very much for coming and being with us here today.

Thank you. Have a good holiday.

(HEARING CONCLUDED)